



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
Georgia**

**Application for 2010
Annual Report for 2008**



Document Generation Date: Monday, September 28, 2009

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Georgia's assurances and certifications are available on file in the state's Title V agency, the Department of Human Resources, Division of Public Health's Family Health Branch (2 Peachtree Street, Atlanta, Georgia 30303; 404/657-2850).

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

The Georgia Department of Human Resources (DHR) and its Family Health Branch (FHB) recognize the importance of public participation in the planning and implementation of maternal and child health (MCH) services. Public input is obtained in a variety of ways. DHR conducts annual public hearings. The Georgia Legislature's House and Human Services Budget Subcommittee holds a public hearing yearly on seven federal block grants, including the MCH Block Grant. To facilitate local input into the state's Title IV application as well as state-level planning, FHB utilizes and publicizes an email address (mchblock@dhr.state.ga.us) and web pages (<http://health.state.ga.us/programs/family/blockgrant/index.asp>). As part of Georgia's 2005 MCH needs assessment process, eight focus groups, comprised of a cross section of MCH stakeholders, providers, and consumers including parents of children with special needs, members of the Latin-American community, parent advocates, and teens, were held statewide in urban and rural locations. Web-based surveys were conducted, focusing on needs, gaps, barriers, emerging issues, and what was working well in Georgia's MCH System. The information obtained in the focus groups and stakeholder interviews was utilized in establishing the state's MCH priorities. /2007/ DHR held budget hearings across the state in May and June 2006 to obtain comments from the public on the services they felt were important for DHR to provide in State Fiscal Year (SFY) 2008. The 2006 Georgia Legislature held its annual block grant review on January 19, 2006. A parent of a child with special health care needs reviewed this block grant application. //2007// /2008/ The annual legislative block grant review was held on January 19, 2007. //2008// /2009/ Georgia's annual legislative block grant review was held on January 25, 2008. //2009//

//2010/ 2010/ The state's annual legislative block grant review was held on January 23, 2009. Effective July 1, 2009, the Division of Public Health (DPH) moved to the Department of Community Health (DCH). See attached organizational charts and Section B. Agency Capacity for additional information. Under the reorganization, the Office of Birth Outcomes

***(OBO), formerly the Family Health Branch (FHB), is now the Office of Maternal and Child Health (MCH). //2010// //2010//
An attachment is included in this section.***

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

FFY 2010 Needs Assessment Update: In 2005 the Family Health Branch conducted a statewide assessment of needs and assets, including an environmental scan of key factors that impact maternal, child, and adolescent health in Georgia. Recognizing that assessment is an ongoing process, the Office of Birth Outcomes has undertaken an abbreviated environmental scan to gain additional information about MCH gaps, barriers, needs, and emerging trends. Findings are highlighted below. In addition, planning is underway for the state's FY 2010 MCH Block Grant Statewide Five-Year Needs Assessment as well as a early childhood social emotional environmental scan to be conducted by Georgia's Early Childhood Comprehensive Systems (ECCS) Initiative (Office of Birth Outcomes is the ECCS grantee).

State Profile:

- A study conducted by Election Data Services shows that with a population growth of about 2.3% between 2000 and 2008, Georgia could gain an additional congressional seat. The new district would be located in the area of the state with the greatest population growth, metro Atlanta and suburbs northwest of the city.
- Georgia, like many other states, has experienced a significant economic downturn over the past year. In 2008, the state tied for seventh worst economy with Indiana and Arizona. Significant job losses have been seen in housing/real estate and manufacturing, in particular. Georgia lost 3.4% of its jobs in 2008 and the state's economy contracted 0.6%. Revenue collections are down 9.5 percent for the current fiscal year that ends June 30, 2009. An additional 4 percent drop has been predicted for the new fiscal year that begins July 1. A shortfall of \$500 million is predicted for the current fiscal year and \$700 million for the next fiscal year. In 2008, state agencies were directed by the Governor's office to decrease non-essential spending, implement hiring freezes and employee furloughs, and limit non-essential travel. The 2009 Georgia General Assembly's amended 2009 fiscal year budget and new 2010 budget plan included further cuts. As a result of a continued decline in state tax revenues, Governor Perdue has ordered state agencies to make additional cuts in their June 2009 budgets. The full impact of these cuts on the delivery of health care in Georgia is not known as this time.

MCH Population's Health Status:

- The recently released National Survey of Children's Health (NSCH), 2007 data provides a significant opportunity for Georgia's block grant and needs assessment efforts. The NSCH offers standardized data for Georgia to compare itself to the U.S. as well as other states; and to compare Georgia's 2003 NSCH data to 2007. The NSCH help fill current data gaps in the state, especially among preschool and elementary school age children, offering unique data that helps stimulate partner engagement. The NSCH is a public use data set, facilitating the inclusion of students and fellows -- the future maternal and child health work force -- into the block grant and needs assessment processes.

While analysis of the NSCH by the Division and its partners will contribute to Georgia's ongoing child health efforts, the Data Resource Center for Child and Adolescent Health has provided readily accessible comparisons of preselected measures from the NSCH. Three areas were identified where Georgia is significantly worse than the U.S.: 1) Overweight and obese children, 10 to 17 years old; 2) inadequate insurance for children's needs; and 3) neighborhoods with parks, sidewalks, libraries, and community centers.

The Data Resource Center for Child and Adolescent Health also identified two areas where

Georgia appears to be improving, compared to 2003: 1) Children 0-5 years old ever breastfed (2003: 66.2%; 2007: 74.1%) and 2) children with a preventive medical visit in preceding year (2003: 75.1%; 2007: 88.3%).

- Over the past, reports of child abuse and neglect in Georgia have begun increasing. Reports suggest that the "slight upward drift" in reports, after recent sharp declines, can be attributed to the economic downturn the state has experienced. Since July 2008, reports of abuse and neglect have increased by 1.9% to 11,556 reports. The previous year, reports dropped sharply by 37.2%. State and county child welfare workers have worked aggressively to provide families with help. The number of family support cases has increased from 85,276 in March 2008 to 126,307 a year later.
- A recent study by the University of Georgia has found that lowering the drinking age (currently 21 in Georgia) increases unplanned pregnancies and pre-term births among young women. With a drinking age of 18, study researchers found that prenatal alcohol consumption among 18 to 20 year old women increased by 21%, the number of births in this age group increased by 4.6% in white females and 3.9% in African-American females; the likelihood of women under the age of 21 having a low-birth weight baby increased by 6%; and the likelihood of premature birth increased by 5% in white females under the age of 18 and by 7% in African American women under the age of 18. (University of Georgia May 27, 2009 press release)//2010//

III. State Overview

A. Overview

//2009/ The Georgia Division of Public Health (DPH) has restructured using a new functional model to better align its human and financial resources and support public health at the local level. This model groups similar tasks and experiences together. The majority of the Family Health Branch's programs are now located in the Office of Birth Outcomes (OBO), which serves as the state's Maternal and Child Health Title V agency. An overview of DPH's new model is provided Section B. Agency Capacity Section.//2009//

//2010/ Effective July 1, 2009, DPH moved to the Department of Community Health (DCH). See attached organizational charts and Section B. Agency Capacity for additional information.//2010//

State Profile: Georgia is one of the largest states east of the Mississippi River with the country's ninth largest population. It is the fifth fastest growing state nationally, both numerically and percentage-wise.

Race/Ethnicity: Georgia's population growth is driven by natural increase (i.e., births versus deaths), domestic and international migration. It is the 13th top destination for international immigrants and second for domestic migrants. It ranks 3rd nationally in the number of Blacks and 5th in the percentage of Blacks in the overall population of the state.

Age: Georgia's population continues to grow younger compared to the U.S. as a whole, ranking 6th in terms of the lowest median age. The state ranks 4th nationally in the percent of its population who are of working age.

Uninsured: Georgia ranks 9th nationally in the total number and 14th percentage-wise (16.4%) of uninsured residents. In 2002, 963,000 adults, about 18% of Georgia's population, were uninsured. The disproportionate impact on racial and ethnic groups is reflected with 13% of Whites, 25% of Blacks and 29% of Hispanics not having insurance. Nearly 275,000 of Georgia's uninsured are children under the age of 18. ***//2010/ Twelve percent of Georgians are uninsured. According to 2008 data, there are 307,000 uninsured children in Georgia -- more than one in nine children in the state (12.1%).//2010//***

Health Delivery System Environment: Georgia's health delivery system consists of four components: private providers, hospitals, community health clinics, and the state's public health system, which has two separate elements: the Medicaid/PeachCare payment system and county public health services. The Department of Community Health (DCH) administers the state's Medicaid and State Child Health Insurance Program (SCHIP), PeachCare for Kids programs. Georgia has over 800,000 enrollees under age 21 and 129,000 women 21 year of age or older in Medicaid and about 200,000 enrollees in PeachCare. //2007/ In June 2006, about 600,000 low income adults and children who live in metro Atlanta and Middle Georgia were matched with one of three care management organizations. Medicaid began requiring individuals applying for the family Medicaid program to present proof of income before they could start receiving benefits. The only exception is for pregnant women and their newborns, who can receive immediate prenatal and postnatal care without waiting for eligibility verification. Medicaid also began covering only emergency care for illegal immigrants. //2007// //2008/ Because of federal funding shortfalls, enrollment in PeachCare was closed effective March 11, 2007. At the time of the freeze, more than 300,000 children had PeachCare coverage. Enrollment was reopened July 12 with a cap of 295,000.//2008// //2009/ In 2006, Medicaid Care Management Organizations (CMOs) were implemented statewide in Georgia. Babies Can't Wait (BCW) was not carved out of the CMOs. Approximately 60% of infants and toddlers enrolled in BCW were transitioned from fee-for-service Medicaid to CMOs. This transition impacted BCW private providers in several ways: 1) the CMO credential process was long and frustrating for many providers; 2) provider

rate of reimbursement was decreased; and 3) some providers have experienced reimbursement delays. Many private providers have left the BCW program, thus delaying the initiation of services or greatly decreasing provider capacity. Congress reauthorized SCHIP in September 2007. Georgia received \$325 million. The PeachCare enrollment cap remains in effect. //2009// **/2010/ DPH, including MCH, was transitioned to DCH effective July 2009. //2010//**

Service delivery in the state's public health system is carried out by 159 county boards of health that are combined into 18 districts. Each district is led by a physician district health officer who reports to the state DPH office. The county boards of health provide direct health care services, environmental health activities, and work with community partners in their county around issues of common concern.

A more in-depth state profile is provided in the Needs Assessment Section of this application. /2007/ Updates to the state profile are provided in the Summary Section of the Needs Assessment.//2007// /2008/ Updates to the state profile are provided in the Update Section of the Needs Assessment.//2008// /2009/ State profile updates are provided in the Needs Assessment Update Section.//2009// **/2010/ See the Needs Assessment Update for state profile updates.//2010//**

Determining the importance, magnitude, value and priority of competing factors upon the environment of health care delivery in Georgia: Over the past five years, FHB has continued to strengthen its infrastructure, expand stakeholder relationships, and engage local public health agencies and providers in carrying on activities at all levels of the pyramid. The Branch's directions, key initiatives, and activities have been guided by the comprehensive FY 2000 and FY 2006 needs assessments as well as ongoing environmental scanning to identify emerging issues that impact MCH. The FHB's mission statement provides the values framework that guides its operations:

Vision/Mission Statement - We believe that healthy, well-educated children and families are the keys to optimal individual growth and development essential to maintaining safe and economically sound communities. We believe in ethical decisions and actions, prevention, community ownership, and commitment to a scientific process. Therefore, we are committed to promoting the physical, mental, spiritual, and social well being of children and families through partnerships with communities. These beliefs will be reflected in all policies, procedures, program development and funding mechanisms (decisions) that are part of any business done by, with or on behalf of the Family Health Branch. **/2010/ FHB is now the Office of Maternal and Child Health.//2010//**

National/State/ and Community Initiatives Impacting Georgia's MCH System: Initiatives that MCH has either primary responsibility for or a major collaborative role are highlighted below.

Asthma: Georgia Addressing Asthma from a State Perspective (GAASP), led by DPH, is composed of more than 30 representatives of academic institutions, advocacy groups, professional organizations, public and private healthcare centers, and a private foundation. GAASP examined the prevalence, mortality, and morbidity in Georgia in developing its the Burden of Asthma in Georgia 2003 Report and The Strategic Plan for Addressing Asthma in Georgia 2004. GAASP has awarded grant-in-aid funds to eight Georgia public health districts/coalitions to conduct interventions and implement asthma prevention strategies to serve communities that are disproportionately affected by asthma. FHB has contracted with a local university to provide an asthma case management train-the-trainer program to a public health nurse (PHN) representative from each health district./2007/ GAASP contracted with Georgia State University in 2005 to train public health nurses to become leaders in asthma case management and collaborated with Georgia's CSHCN program, CMS, through the Title V Block Grant, to provide care coordination. One-year grant-in-aid funds were awarded to eight public health districts. //2007// /2008/ The district CMS program contracts with various community partners to co-sponsor events to help families participated at a reduced rate or at no cost. In the

last fiscal year, CMS has supported Asthma Camp Huff and Puff, YMCA Healthy Kids Day, and Asthma Camp Iwannabreathe.//2008// /2009/ CMS has continued to provide care coordination for all CMS asthma clients. The CMS client asthma questionnaire is completed biannually. An asthma questionnaire data collection process has been established for the CMS quarterly reporting system. Meetings have been held with the asthma program manager to discuss future collaboration with GAASP.//2009// **/2010/ With input from the Georgia Asthma Advisory Council (GAAC), funds were awarded to four health districts to conduct interventions that can achieve long-term positive health impacts, such as reducing the number of deaths, hospitalizations, emergency department visits, school or workdays missed, and limitations on activity due asthma. District strategies focus on health promotion; activities include education, awareness and environmental and policy changes. GAAC continues to provide ongoing support to GAASP. The GAASP program manager is working with the GAAC chair to expand GAAC membership. She is also working with Girl Scouts of America-Georgia to provide asthma training, with participating Girl Scout troops earning an asthma education patch. GAASP and the Georgia Academy of Family Physicians (GAFP) are continuing to explore opportunities for ongoing collaboration.//2010//**

/2008/ BabiesCan't Wait (BCW) and Title V CSHCN Program Restructuring: the Part C (BCW) Program began work on a comprehensive system assessment and restructuring in December 2006. Final proposed changes were released for public review and comment in Spring 2007. Re-design efforts include clarification and restructuring of key BCW system components, including child find and public awareness, referral, screening, intake, evaluation/assessment, eligibility determination, IFSP development, service coordination and service delivery. The Title V CSHCN Program has begun work on program and system change for more effective and efficient use of resources and for on-going sustainability. A request for a MCHB/HRSA Technical Assistance Project "State Leadership Workshop on Title V and Medicaid" has been submitted to improve EPSDT and Child Health, including CSHCN.//2008// /2009/ OBO hired the Sojo, Inc. Team to support re-branding and program change; work with priority target audiences; help develop appropriate communications materials and key messages; and support the Georgia Families Matter web site launch (<http://www.georgiafamiliesmatter.org/>).//2009// **/2010/ State BCW staff have worked to enhance local BCW program general supervision and monitoring. The state database has been revised to capture additional data for federal reporting and fiscal management. State review teams completed onsite monitoring reviews of eight district BCW programs. A fiscal analysis of the program was conducted by Risk Performance Management to help the state better determine and project program costs as well as service utilization levels. Eight additional district monitoring visits were conducted to evaluate the implementation of tiered service coordination, which began in September 2007.//2010//**

/2009/ Birth to Five System: In December 2006, a major system re-design of Georgia's Part C program was initiated to better align resources. The new Birth to Five System focuses on the development and provision of a seamless system of service among all public health programs serving young children that is effective, family-centered, efficient, sustainable, high performing, and consistently meets state and federal performance indicators. The expectation is that children who are at risk for poor health and developmental outcomes will be identified early and those suspected to have developmental delays or negative health indicators will be linked to effective, appropriate, and sustainable services that achieve results and prevent or ameliorate negative outcomes. Children 1st is used as the single point entry for BCW. Children 1st screenings are reviewed on all children referred through CAPTA. A tiered service coordination model is used to determine frequency and intensity of service coordination for all children. Children 1st includes the use of developmental specialists at the district level along with Birth to Five Review Teams (i.e., Children 1st, BCW, HRIFU, CMS, UNHSI, Child Health) that meet regularly.//2009//

Breastfeeding Promotion, Education, and Support: Using the Loving Support Campaign, several breastfeeding initiatives have been initiated including Building a Breastfeeding Friendly Community and Educating Physicians In Their Community ((EPIC). Nine districts have been

awarded funds to hire 32 peer counselors. //2007/ FHB entered into contracts with AFP, GA- AAP, and the OB/GYN Society to assess physician breastfeeding awareness.//2007// /2008/ Eight health districts were awarded WIC Breastfeeding Peer Counselor funding. Over 70 former WIC participants have been trained as peer counselors, using the peer counselor curriculum. A contract was awarded to GA-AAP for the development and implementation of the EPIC breastfeeding peer-to-peer program.//2008// /2009/ GA-AAP has a contractual agreement with WIC and OBO to implement the EPIC (Educating Physicians in their Community) Program. A team of physicians and nurses trained to deliver breastfeeding education to doctors and their staffs offer the trainings statewide in local offices and clinics. Eight health districts were awarded WIC Breastfeeding Peer Counselor funding in 2007. Through the program about 500 WIC recipients have received breastfeeding support.//2009// ***/2010/ The EPIC program continues under a contractual agreement with selected contractor GA-AAP. Since July 2008, 105 programs have been provided in physician offices across the state with a total of 1,116 attendees. Currently, there are 36 Peer Counselors in the seven of the original nine district Breastfeeding Peer Counselor programs. A state breastfeeding coordinator was hired in January 2009 and is now working in the Women's Health Unit.//2010//***

/2010/ Children 1st/First Steps Pilot Project: To ensure a more effective working relationship, DPH and Prevent Child Abuse Georgia are implementing a Children 1st/First Steps pilot project. The goal is better resource utilization and increased capacity across both programs.//2010//

/2008/ Children's Mental Health Care: Georgia received a \$21 million federal grant to provide community alternatives to psychiatric resident treatment facilities for children and teens with serious emotional disorders. The grant will also help pay for crisis stabilization services.//2008// /2009/ A Medicaid waiver application has been submitted to the Georgia Department of Community Health.//2009//

Children and Youth with Special Needs (CYSN) Initiatives: CMS, the FHB Title V CSHCN program, has experienced several major system/infrastructure impacts over the last year, including the financial impact of changes in emergency assistance (EMA) on uninsured CMS enrollees, the need to provide services for families and children with special needs who were evacuees from Hurricanes Katrina and Rita, and the programmatic and fiscal impact of the state's move to Medicaid managed care. CSN staff participated in a FHB meeting with Powerline, Parent to Parent, Healthy Mothers Healthy Babies, and United Way to discuss integration and coordination across all referral directories. BCW trained all district staff on the new federally mandated child and family outcome data. A stakeholder meeting was held on implementing IDEA focused monitoring in SFY 2007. BCW worked with the National Early Childhood Technical Assistance Center on the development of tools for state use in assessing early intervention finance systems and in planning multiple training/technical assistance efforts aimed at Part C systems and finance. Training sessions on CAPTA referrals to BCW and public health programs were held statewide for DFCS case workers.//2007// /2008/ Federally mandated child/family outcome data and focused monitoring for Part C programs has been initiated. Work continues on the CSEG grant to support data sharing with the Department of Education. CAPTA training sessions have been completed; future trainings using the developed curriculum have been conducted by DFCS. The first three-year cycle of the CMS quality assurance programmatic /fiscal reviews has been completed. The "Transition Planning for Adolescents with Special Health Care Needs and Disabilities" manual received DPH approval. Through district specialty clinics held in local communities for CMS clients, specialty services have been made available to over 1,500 children and youth not enrolled in CMS. Staff provided technical assistance for the Georgia Parent 2 Parent grant application for the MCHB Family to Family Health Information Center, which was approved. //2008// /2009/ CMS staff participated in the BCW service coordination and service delivery redesign, including site visits, training and meetings. A transition manual, "Transition Planning for Adolescents with Special Health Care Needs and Disabilities - A Guide for CMS Coordinator," has been developed. CMS Coordinators were trained on use of the manual. CMS continues to conduct quality assurance fiscal reviews in Georgia's 18 health

districts (three-year cycle) and provide technical assistance as needed related to record documentation and fiscal management. In addition, CMS helps link CMS clients in foster care to the Health Check system and collaborates with the asthma program manager on asthma surveillance and with the American Lung Association on asthma education and management. At the client level, with passage of the Georgia Security and Immigration Compliance Act (SB 529) which became law in July 2007, CMS clients 18 years and older are now required to sign the Declaration of Citizenship/Legal Alien Status form in order to continue their eligibility for the CMS program.//2009// **/2010/ As a result of a 2008 U.S. Department of Health and Human Services, Office of Civil Rights Compliance Review, DPH has made changes in how SB 529 is executed statewide. A new Declaration of Citizenship or Lawful Presence for Public Benefits form was implemented in county health departments in February 2009. CMS clients 18 years and older are no longer required to sign the Declaration of Citizenship/Legal Alien Status form in order to continue their eligibility for the CMS program.//2010//**

Early Childhood Comprehensive Systems (ECCS) Initiative: A MCHB Early Childhood Comprehensive Systems (ECCS) two-year planning grant was awarded to FHB in 2003. DPH serves as co-leader with the Department of Early Care and Learning (DECAL). A planning committee, composed of key partners from multi-agencies, is charged with fulfilling the ECCS mission, which is: "to build and sustain a comprehensive early childhood system through collaboration of service providers, families, communities, and policymakers" that integrates access to medical and dental home; mental health and social-emotional development of young children; early care and education; parenting education; and family support. /2007/ The 2005 Georgia General Assembly passed House Resolution 518 creating the House Study Committee on Children: Newborns to Age 5 to study of the conditions, needs, issues, and problems of young children and recommend any action or legislation deemed necessary or appropriate. The ECCS Planning Committee re-examined its 12 top priority areas in light of the Study Committee's findings, determined the initial status of Georgia agencies and organizations' work on each priority area, and revisited and combined related priorities and strategies. //2007// /2008/ Work has focused on five cross-cutting areas: navigator teams, a web-based clearinghouse, training, public awareness and promotion, and developmental screening. A web-based ECCS clearinghouse has been designed and implementation is underway.//2008// /2009/ ECCS work group mini grant funds are being used to help conduct a study on current family support practice and training by state and state-level agencies and organizations; provide resources to Better Brains for Babies Train the Trainers about basic concepts for enhancing parents' knowledge of child development; assist 14 community agencies in providing Parenting in the Real World parenting classes; and provide stipends for parents to attend ten Love n' Logic parenting courses in Clarke County. //2009// **/2010/ The grant has supported a study to examine current family support practices and training for state agency personnel who provide services for young children and their families in Georgia and to identify practice and training strengths, gaps, and barriers. Work has continued on the ECCS web-based clearinghouse. ECCS recently received funding for an additional three-year funding period. Grant activities will focus on early childhood social-emotional development.//2010//**

Finding Opportunities through Collaboration, Understanding, and Science (FOCUS): FOCUS, a state and local public health partnership to address Georgia's infant mortality rates and poor birth outcomes, is initiating and facilitating community-oriented, data-driven, and system focused planning processes at the local level. Key data include an analysis of Perinatal Periods of Risk data and mapping of incidence of fetal and infant mortality in some of the counties with the state's highest rates and numbers of infant mortality. Current FOCUS counties include Clayton, Chatham, and Lowndes./2007// /2008/ The state is providing financial and technical support to improve birth outcomes in Clayton County. Key work includes developing and sustaining a community collaborative; facilitating a 5-year evidence-based, data driven plan to improve birth outcomes; engaging the larger community in improving birth outcomes; and increasing staff and community knowledge and awareness of birth-related issues.//2008// /2009/ Eight counties have been designated as FOCUS counties. The Family Planning Program has applied for Family

Planning Expansion grant funds that, if awarded, will help support a Family Planning service/clinical position in four FOCUS counties. //2009// ***/2010/ Using Family Planning Expansion grant funding, MCH's Family Planning program allocated funds to three Georgia counties with high infant mortality rates. Funding is being used to increase staffing capacity./2010/***

Folic Acid and Prevention of Neural Tube Defects: To improve pregnancy outcomes, the Nutrition and Programs and Services Sections partnered with the Georgia Folic Acid Coalition and Emory University Rollins School of Public Health to complete a pilot project in three local agencies to increase folic acid awareness. Women's Health and Nutrition Section staff co-chair the DHR Folic Acid Quality Team and are members of the Georgia Folic Acid Coalition. /2007/ DHR will implement a six-month pilot of expanded folic acid supplementation and education in a selected number of Family Planning clinics. Based on pilot results, these services will be expanded to other Family Planning clinics throughout the state.//2007// /2008/ Pilot project was completed December 2006. All health districts were provided with Spanish and English March of Dimes folic acid brochures. Surveys were given to women receiving vitamins and responses were entered into an Access database containing over 5,000 surveys. Results indicated surveyed clients received and were receptive to the multivitamins and education component. //2008// /2009/ The Georgia Folic Acid Task Force has been re-established as the MCH Nutrition Advisory Council. The Council, which will support the work of DPH's Target: Healthy Mother, Healthy Baby program, will develop a strategic plan to promote healthy nutritional behaviors among MCH populations, including promoting folic acid supplementation and folate-rich food. It will also assist DPH's Women's Health Section in expanding the Georgia Academy of Family Physicians (GAFP) contract to include nutrition-related deliverables targeted at improving the preconceptional health of Georgia women.//2009// ***/2010/ The MCH Nutrition Advisory Council continues to promote healthy nutritional behaviors among MCH populations, including promotion of folic acid supplementation and folate-rich foods./2010/***

Foster Care: Since 2003, a group comprised of representatives from the Georgia Chapter of the American Association of Pediatrics (AAP), DCH, DFCS (state and local), DPH (state and local), and the Adoptive Parents Association, has been meeting to address the well being of children in DFCS custody. DPH's role is to assure preventive health care (Health Check) is provided to children in foster placement through outreach and follow-up to foster parents and children. /2007/Appendix V for Foster Children -- "Protecting Children -- How to Report Abuse and Neglect and Guidelines for Health Check Services and Sharing Medical Records between Public Health and DFCS" has been added to the Policies and Procedures for Health Check Services manual. Training sessions focusing on child development, the importance of developmental screening, and how to access Children 1st and BCW programs and services were provided to county DFCS Child Protective Services staff. /2008/ DFCS implemented a new policy mandating all eligible children ages birth to five who are in foster care participate in Children 1st. Training sessions on the Child Abuse Prevention and Treatment (CAPTA) have been provided; ongoing training on the curriculum continues through DFCS and Georgia State University.//2008// /2009/ Georgia is using two family-centered approaches to engage families in case planning. A Family Team meeting is held within nine months of a child entering foster care to begin initial case planning with the family. Families are engaged in and partners in decision-making. A Multi-Disciplinary Team meeting (MDT), conducted within 25 days of a child's placement in foster care, concludes the initial case planning with the family. The MDT process engages the family and professionals from the community to address the child's needs for placement stability, safety, well-being, and permanency.//2009// ***/2010/ DHR and DCH agreed to use Children 1st as the single point of entry for all children in foster care under the age of 18 and for non-CMO children (ages birth to 3) identified via CAPTA. A training on Health Check and Children 1st was provided on 1/21/09 for all health districts. The referral policy has been updated and disseminated. A process and plan for program improvement has been initiated by DFCS to enhance compliance with all CAPTA requirements. The Foster Care Project (FCP) in Floyd County continues to be an excellent demonstration of collaboration between DPH and DFCS in the provision of case management support and preventive and comprehensive health services***

to children at risk for abuse and/or neglect. FCP staff assist DFCS to ensure foster care children receive timely initial physical examinations, immunizations, dental care, and case management for further health needs. In FY 2008, 99 children enrolled in the FCP received health care screens, and 87% of newly enrolled foster children received their physical within 10 days of enrollment. //2010//

Georgia Registry of Immunizations Transactions and Services (GRITS): GRITS works with companies, health care organizations, and communities to make sure certain vaccination levels are high. The program collaborates with nearly 3,000 partners statewide, including Kroger Health Solutions, the first pharmacy to build an interface with GRITS for sharing immunizations.//2007// /2008/ In 2006, the GRITS Program reached a milestone of 60 million immunization transactions for the over 6 million clients recorded in the system.//2008// /2009/ GRITS continues to collect and maintain current vaccination records to promote effective and cost-efficient disease prevention and control. Georgia's immunization providers have quick and easy access to immunization records on individual children and are able to generate a variety of reports on their immunization status. Partners include Children's Healthcare of Atlanta, GAHP, GA-AAP, and the Georgia Association of Physician Assistants.//2009// ***//2010/ GRITS continues to enroll additional providers to view and add new vaccination information. Almost 4,000 private providers are using the GRITS system with 8.2 million clients entered and over 80 million immunizations recorded.//2010//***

/2009/ "G-Force" Initiative: As part of the "Performance Management & Quality Improvement" pilot, in June 2008 DPH launched its first G-Force initiative with the BCW program. G-Force is a performance management tool using data to drive performance and promote best practice. Using a participatory and interactive process between state and district staff, it provides a learning environment for districts where peers learn from one another; real-world solutions from the field of practice, an opportunity to identify and diffuse best practices in real time; and better provision of technical assistance by the state office.//2009// ***//2010/ Since the introduction of G-Force in April 2008, monthly G-Force Video Interactive Conferencing System (VICS) meetings have been held with BCW program staff. Bi-weekly planning meetings have been held at the state office that include the participation of BCW program coordinators from various districts.//2010//***

/2008/ Grandparents Raising Grandchildren (GRG): To help support the 92,000 Georgia grandparents raising grandchildren, a collaborative team has been formed with representatives from DFCS, Division of Aging, Office of Child Support Services, DMHDDAD, and DPH. The team has identified enhanced services for GRGs as well as multiple points of entry for a single system of care for grandparent families that are helping to reduce multiple visits to DHR offices because of misinformation or lack of information about requirements for and access to services. DPH is piloting the GRG initiative in three public health districts.//2008// /2009/ The Coastal Health District joined the initiative in 2008. DPH developed an orientation and procedure manual for PH staff and collaborated with the DHR Project Team to sponsor a Statewide Interagency Grandparents Raising Grandchildren seminar in Macon that included national speakers and opportunities for local partners to network. In March 2008, DPH partnered with WIC to establish Kinship Care Navigators in selected metro counties. These Navigators will be positioned in WIC clinics to help identify grandparents raising grandchildren and assist them in accessing needed services within public health and with partner agencies.//2009// ***//2010/ DPH continues to work with the collaborative team to enhance services for GRGs.//2010//***

HIV Counseling and Testing: In 2003 the DPH HIV Section and FHB Family Planning Program collaborated on a pilot designed to increase the number of family planning clients routinely tested for HIV. Family planning clients were routinely tested for HIV with standard serum antibody tests during initial or annual visits, and as indicated. FHB and HIV Section staff developed and offered medical providers information on the impact of maternal high-risk behaviors on child development. /2007/ The pilot was expanded to health districts 3-2 and 4. Both pilots are routinely testing for HIV during initial or annual family planning visits and as indicated. //2007// /2008/ The

DPH HIV Section and FHB are currently collaborating on a project designed to increase the number of teens routinely tested for HIV. All teen clinics have agreed to provide routine opt-out HIV testing using the OraSure collection device. //2008// /2009/ Thirteen of the 18 health districts have implemented opt-out HIV testing in some or all of their family planning clinics.//2009// ***/2010/ The Perinatal HIV Program collaborated with the Georgia Academy of Family Practitioners (GAFP) to increase HIV counseling and testing for pregnant women. GAFP has conducted provider education, training and awareness activities on Georgia's HIV Opt-Out Pregnancy Screening Act of 2007 and on HIV treatment for infected pregnant women and women of child bearing age.//2010//***

/2010/ Infant Mortality: To realize the declines in infant mortality that Georgia experienced in previous decades, and to reduce racial disparities in poor birth outcomes, DPH recognizes the need to think in new directions. To this end, an Infant Mortality Rate Summit was held on December 19, 2008 to enlist and promote collaborative support among Georgia's many stakeholders. The summit drew more than 150 decision makers who recommended nearly 100 strategies that can be achieved through interagency collaboration. Three major topical areas framed the summit sessions: Policy and Practice Considerations, Going Beyond the Hospital Walls, and Georgia in Action. In addition to featuring national and state experts, the summit highlighted selected best practices that are being implemented currently in local communities in the state to decrease infant mortality. For example, District 8-2 (Albany) has established a community group to look at district perinatal outcomes and teenage pregnancy rates. The team, which includes local public health staff as well as an area hospital administrator and representatives from AHEC, Georgia Southern School of Public Health, and Albany Primary Care FQHC, is creating an integrated medical care and ancillary support model for women.//2010//

/2008/ Integrated Family Support (IFS) Initiative: In FY 2007, DHR launched a home visitation project in an effort to reduce child abuse and neglect, improve child health outcomes, and provide support to Georgia's vulnerable families with infants at highest risk for child maltreatment. DHR entered into a contract with the Marcus Institute to provide training to public health staff on an evidence-based model to decrease child maltreatment in families at risk. Trained, supervised Public Health staff will provide frequent and intensive home visits with families of young children who are at risk for child maltreatment. Nurses/health educators will use standardized tools and curricula to teach parents about infant and child health, home safety and cleanliness, and parent-child interactions. Home visits will also provide families with information to promote family planning and child spacing at least two years apart and to educate families on child development through the use of standardized developmental screening tools and other developmental guidelines. DHR has contracted with Georgia State University to conduct a process and impact evaluation of the model. IFS implementation began March 2007 in Bartow and Cobb counties. Two public health staff have been trained in each county to provide intervention through home visits to identified families. DPH has collaborated with DFCS and with Prevent Child Abuse Georgia to provide a child abuse and neglect mandated training for all public health nurses and staff.//2008// /2009/ The pilot project was evaluated and, based on evaluation findings, the program has been restructured to include home visitation services in DPH, Division of Family and Children Services (DFCS), and DMHDDAD. Due to a nursing shortage and increased costs to hire and retain qualified nurses, recruitment efforts to hire home visitation staff will now target social workers, LPNs, health educators, and early childhood specialists. All pilot sites will be closed by the end of June 2008. The new project will begin July 2008 in three new counties.//2009// ***/2010/ Due to restructuring of DHR, no additional funding will support this effort. DPH therefore has developed an MOU with DFCS to support a transition plan to ensure that families currently being served will complete the program.//2010//***

/2007/ Live Healthy Georgia Campaign: DHR has launched a campaign to help Georgians live healthier lives and reduce the burden of chronic disease and other illnesses. A web site (<http://www.livehealthygeorgia.org>) includes information on getting appropriate health screening, eliminating tobacco use, increasing and maintaining physical activity, eating healthy, and

achieving and maintaining a state of mental wellness //2007// /2009/ Under division reorganization, DPH is increasing its focus on wellness and priority health outcomes designed to improve the health of Georgians. These outcomes reflect the Governor's agenda for Live Healthy Georgia and its efforts to bring together governmental and non-governmental partners to "Stop Smoking, Eat Healthy, Be Active, Get Checked, and Be Positive." //2009// **/2010/ DCH recently launched an updated health-care web site (www.georgiahealthinfo.gov) that helps consumers find hospitals, pharmacies, clinics, outpatient centers, and long-term care facilities. The site includes search tools that enable users to enter their address and health care problem and the system will search for individual hospitals, doctors, pharmacies, clinics or health centers in the area that can handle the problem. In addition, the site includes tips on choosing a doctor, healthy living and various to compare health-care providers.**//2010//

Male Involvement: Using Title X and TANF funds, FHB initiated services at state and local levels, focusing on improving men's reproductive health, including a Title X special initiative with Grady Health System's Teen Center to enhance its male involvement services and promote sexual health and development in young adolescent males that will help them learn to care for their reproductive health. Other male involvement partners have included the Georgia Commission on Men's Health, the DPH Cancer Control Section and its Prostate Cancer Task Force, and community-based organizations such as the Fulton County Male Health Task Force. /2008/ FHB is working with the Grady Health System's Teen Clinic to develop a CD-ROM focusing on African-American males about the importance of protecting their health now and in the future. The CD has been presented to the Women's Health Coordinators and three health districts have received training on using the CD.//2008// /2009/ Women's Health worked with DHR, the Commission on Men's Health, and Georgia State University Health Policy Center to publish a "Men's Health Report" that was disseminated during Men's Health Week.//2009// **/2010/ Women's Health assisted the Clayton County Health Department and Grady Teen Center in developing grant applications to enhance male involvement activities within their family planning programs. Women's Health continues to work collaboratively with the Georgia Commission on Men's Health.**//2010//

/2007/ Maternal Depression: Six regional symposiums were conducted on maternal depression. Over 260 staff from public health, mental health, DFCS, hospitals, extension services, early intervention, child protection, faith communities, and other organizations were trained on the use of the Edinburgh Postnatal Depression Screening Tool and ways to integrate use of the scale into current work, an overview of mental health and depression, cultural competence and mental health, maternal depression, and spirituality and mental health. In collaboration with Georgia's Healthy Start sites, FHB contracted with the University of Washington to provide DPH staff maternal mental health training. A Mental Health Private Sector Provider Resource Directory has been disseminated electronically and in hard copy statewide to service providers and professional medical and human service societies and organizations. //2007// /2008/ FHB incorporated use of the Edinburgh Depression Screening Tool statewide for screening and early detection of perinatal depression and expanded training to include all health care providers who have direct contact with women and children. Powerline continues to update the Mental Health Provider Resource Directory.//2008// /2009/ Additional trainings were provided to Public Health staff statewide on screening, identification, and referrals of mothers with postpartum depression.//2009// **/2010/ Powerline continues to update the Mental Health Provider Resource Directory.**//2010//

Maternal Substance Abuse: With its partners, FHB developed an issue paper, Improving Outcomes for Mothers and Children -- Addressing Maternal Substance Abuse in Georgia, that includes a framework for addressing maternal substance abuse in Georgia. An internal DPH methamphetamine work group, led by FHB, has been formed with representatives from the various DPH branches, DFCS and the Georgia Poison Center, to develop and implement a comprehensive DPH response to the rising methamphetamine problem in Georgia. /2007/ The Maternal Substance Abuse and Child Development curriculum was funded by BCW. FHB is collaborating with physician organizations on dissemination strategies //2007//. /2008/ FHB held a

focus group meeting with physicians with an expertise or interest in maternal high-risk behaviors to discuss curriculum content. Based on this input, four separate two-hour curriculum training modules (Preconception Health, Alcohol and Other Drug Use, AIDS/HIV and STDs, and Fetal Alcohol Syndrome) were created.//2008//

Newborn Metabolic Screen Program: Legislation, effective January 2007, was passed by the Georgia Legislature that adds 16 additional tests to the Newborn Screening Program panel.//2007// /2008/ In January 2007, the Georgia Newborn Screening Program expanded its mandated screening panel from 11 to 29 disorders, including cystic fibrosis. By the end of May, 12 newborns were diagnosed with cystic fibrosis. A \$40 laboratory fee was also implemented. Screening, follow-up, diagnosis, management, and evaluation for 29 disorders will identify an estimated 136 newborns each year. Updated educational materials have been developed and disseminated to hospitals and providers regarding the expanded screening.//2008// /2009/ As of March 2008, 89 infants have been diagnosed with a metabolic condition and 154 with a hemoglobin abnormality, including sickle cell disease.//2009// **/2010/ As of April 2009, 121 infants have been diagnosed with a metabolic condition and 116 with a hemoglobin abnormality, including sickle cell disease. Follow-up data is now being collected in a central tracking system.//2010//**

Newborn Screening Programs: Universal Newborn Hearing Screening and Intervention (UNHSI): Following the creation of a Governor's State Advisory Committee on Newborn Hearing Screening in 1999, UNHSI was established, with funding from several sources including the tobacco master settlement agreement (MSA), HRSA MCHB, and an Early Hearing Detection and Intervention grant from CDC. Funds were awarded to health districts for the purchase of necessary hearing screening equipment for local hospitals. UNHSI was launched in January 2001. Linkage and tracking mechanisms were implemented to assure timely and appropriate follow-up of infants not passing the hospital hearing screen, with the primary linkages managed through Children 1st. Providers are required to report infants not passing the initial hospital screen, follow up outpatient screen, and those children under age five diagnosed with a hearing impairment to public health as part of the notifiable disease process. Effective January 2005, a hospital screening rate of 95% is required to receive incentive funds. FHB collaborated with MCH Epi to develop a statewide web-based system to track and monitor infants and children identified through Children 1st for hearing screening, surveillance, and quality assurance. FHB was awarded a three-year HRSA grant to provide training on use of the web-based tracking and surveillance system and evaluate its effectiveness. The final version of the UNHSI Resource Guide has been developed to inform providers and the public of the importance and availability of newborn hearing screening and offer resources for follow-up and intervention. /2007/ UNHSI: The NSTS prototype has been developed and two public health districts, two hospitals, and four providers are scheduled to pilot the prototype in August 2006. Statewide NSTS implementation is scheduled for September 2006. UNHSI is developing a standardized training protocol for hospitals that perform newborn hearing screening. /2009/ CMS continues to collaborate with UNHSI to meet client needs through provision of financial support to clients and families in the purchase of audiology supplies, assistance with audiology office visit payments, and provision of case management services. Hearing screening data is reported quarterly. In FY 2007, 2nd quarter, 99% of infants born in Georgia were screened. Of those infants failing the initial screen, 78% were tracked to a follow-up screen. Of those with a failed follow-up screen, 95% were tracked to an audiological evaluation.//2009// **/2010/ In FY 2008, 99% of infants born in Georgia were screened. MCH was awarded a three-year HRSA grant to implement strategies to reduce the number of infants failing the initial hospital screen who are lost to follow-up. Development of the UNHSI module in SENDSS Newborn (formerly NSTS) continues. A pediatric audiologist has been hired to assume the role of State UNHSI Coordinator and a second audiologist has been identified to serve as a consultant.//2010//**

NTD Birth Defects Surveillance: The Georgia Birth Defects Reporting and Information System (GBDRIS) surveillance system is designed to provide information on incidence, prevalence, trends, and epidemiology of birth defects. It collects information on children from birth to six

years of age. GBDRIS is maintained by MCH Epidemiology in DPH. Bi-monthly listings of children with suspected birth defects are generated and provided to each Children 1st District Coordinator. Children 1st Coordinators and CSN Coordinators work together to determine the enrollment status of identified children. //2007/ GBDRIS is conducting active case verification on all reported NTDs. Medical records for all reported cases are requested. A summary, along with Enhanced Surveillance Record Review Worksheet, is completed and revised by a nurse and physician. The Georgia Birth Defects Surveillance Advisory Committee meets on a regular basis. //2008/ GBDRIS is continuing to conduct active case verification on all reported NTDs. //2008// //2009/ Under the DPH reorganization, GBDRIS is maintained by the Birth Outcomes Unit of the DPH Epidemiology Section. Quarterly listings of children with suspected neural tube defects (NTDs) are generated and provided to each Children 1st District Coordinator. Children 1st Coordinators and CSN Coordinators work together to determine the enrollment status of identified children. The Georgia Birth Defects Surveillance Advisory Committee continues to meet on a regular basis. GBDRIS staff work closely with the Newborn Screening Advisory and Operational workgroups.//2009// **//2010/ Quarterly listings of children with suspected neural tube defects (NTDs) are generated and provided to each Children 1st District Coordinator. Children 1st Coordinators and CYSN Coordinators work together to determine the enrollment status of identified children. GBDRIS staff continue to work closely with the Newborn Screening Advisory and Operational workgroups.//2010//**

Oral Health: The Oral Health Section (OHS) has been awarded Georgia Access to Dental Services (GADS) III HRSA funds for a three-year project period. Survey reports have been developed and shared with national, state, and local organizations that impact public policy and program support. GADS I funds have been used to expand district projects that increase access to care. //2007/ Survey reports have been completed and are being shared with national, state, and local organizations. //2007// //2008/ OHS GADS III/States Oral Health Collaborative Systems funds supported the 3rd grade and Healthy Start oral health surveys. Oral Health continues to focus on population-based initiatives, with a special emphasis on fluoride varnish initiatives in collaboration with the medical community and DECAL. Fluoride varnish manuals and oral health training videos are being created to assist the medical, dental, and Head Start providers. A Head Start forum was held to assess need and strategically plan to increase access to care for young children. A follow up forum in May 2007 provided information on Best Practice development statewide. Oral Health collaborated with the Medical College of Georgia School of Dentistry to secure a workforce development grant to provide public health dental clinic internships to senior dental students. Reports measuring access to care through SCHIP and Medicaid programs have been published and shared, including trend analyses 2000-2005. //2008// //2009/ The recently released Georgia Oral Health Program (GOHP) report, The Status of Oral Health In Georgia, 2007 -- Summary of Oral Health Data Collected in Georgia, presents the most current information available on the oral disease burden in Georgia, including data from the Georgia Head Start Oral Health Survey, the Georgia 3rd Grade Oral Health Survey, Georgia Behavioral Risk Factor Surveillance System (BRFSS), and the Georgia Comprehensive Cancer Registry (GCCR). GOPH has applied for a CDC State Oral Health Prevention grant to enhance program infrastructure.//2009// **//2010/ Georgia was awarded a five-year CDC State-based Oral Disease Prevention Program Cooperative Agreement that provides funds to strengthen the Oral Health Program's infrastructure and increase capacity to prevent oral disease and promote oral health. Year one funds have been used to hire an Oral Health Evaluator and Oral Health is in the process of hiring an Epidemiologist, Dental Sealant and Oral Health Education Specialist, and a Fluoridation Consultant. The Georgia Oral Health Coalition was reinstated and is working to advise, help improve, and advocate for dental public health in Georgia. Oral Health continues to contract with the Georgia Rural Water Association to administer the Water Fluoridation Program, with 159 water systems receiving a Water Fluoridation Quality Award from the CDC. Two new mobile dental clinics are being purchased to serve the Lawrenceville and Waycross Health Districts. The Oral Health Medical College of Georgia collaboration has provided dental services in 44 county dental clinics and 14 public health mobile dental clinics throughout Georgia.//2010//**

Overweight/Obesity in Children, Youth, and Adults: Through CDC funding for the prevention of obesity and other chronic diseases, Georgia's Nutrition and Physical Activity Initiative Task Force is implementing grant activities. The Nutrition Section is collaborating with the Office of Health Promotion to take the lead in piloting a six-week worksite wellness program that focuses on improving state employee nutrition and physical activity behaviors and promoting a healthier work environment. The Section has partnered with the Infant and Child Health Team to complete the nutrition height and weight screening guidelines to support Georgia's School Screening Initiative. /2007/ Through CDC funding, DPH and its partners have released a ten-year plan, "Georgia Nutrition and Physical Activity Plan to Prevent Obesity and Other Chronic Diseases, 2005-2015" and launched a web site for the initiative. In March 2005, the Georgia Recreation and Parks Association passed a health resolution on improving healthy choices in vending machines and concession stands. /2007// /2008/ Faith-based and worksite health promotion toolkits have been developed. DHR Worksite Wellness Program activities continue and a website has been developed. Thirteen sites have been selected to pilot the health resolution passed by the Georgia Recreation and Parks Association. School Nutrition Screening Guidelines have been developed to collect the height and weight of school-age children. Nutrition and Physical Activity Grant-in-Aid in Waycross and Augusta continues to support community-based approaches to improve fruit and vegetable consumption, increase physical activity, increase breastfeeding, and decrease TV viewing. Through the HHS Office of Women's Health, a public health educator and a district AHYD coordinator received train-the-trainer education on the BodyWorks program, designed to help parents and caregivers of young adolescent girls (ages 9 to 13) improve family eating and activity habits. CMS serves eligible clients with chronic medical conditions where obesity may be a secondary complication. Such clients are referred to resources to assist them with weight reduction and related nutritional services. CMS is a DAISY Dieters co-sponsor, a group formed to address needs of families in the community as related to childhood obesity. /2008// /2009/ The Nutrition and Physical Activity Grant-in-Aid pilot in Waycross and Augusta continues to support community-based approaches through partnerships and coalition building to promote healthy behaviors in 29 counties. Through a mini-grant and special funding from the Cardiovascular Health Initiative, park improvements have been implemented in Ware County, guidance has been provided on healthy beverages and snacks for vending machines, and vegetable and fruit consumption has been promoted through farmers' markets. The DPH Office of Nutrition's new Target: Healthy Mother, Healthy Baby initiative is working to reduce the prevalence of obesity in women of reproductive age and expand nutrition services to MCH populations in Georgia. /2009// **/2010/ The DPH Office of Nutrition is working with Georgia's Nutrition and Physical Activity Coalition to address the obesity epidemic and hunger and food security through the establishment of the Operation Front-line (OFL) program, a chef-led nutrition education program teaching families how to prepare healthy meals on a limited budget. The Office of Nutrition continues to provide technical assistance and advice to the state's Nutrition and Physical Activity Obesity Intervention team. /2010//**

Perinatal Services: Georgia was one of five states selected by Association of Maternal and Child Health Programs (AMCHP) to receive technical assistance and training from national experts in evaluating perinatal services. In 2004, AMCHP convened its Action Learning Lab (ALL) to help state MCH professionals and their partners from the five states increase their knowledge of perinatal disparities and develop strategies to reduce racial and ethnic perinatal disparities. /2007/ Georgia is developing a state level plan that addresses perinatal health as a continuum from preconception to infant care. /2007// /2008/ The Prenatal Health Partner pilot project, a home-visiting program for high-risk perinatal patients, was implemented in Waycross to encourage birth spacing and improve healthcare for the family, with resultant improved birth outcomes. The pilot, which focuses on African Americans who are at greater risk for poor birth outcomes, includes social case management. A perinatal outreach worker follows patients for up to one year postpartum. /2008// /2009/ In July 2007, the Perinatal Health Partner program was expanded into two additional counties in the Waycross Health District. /2009// **/2010/ The Perinatal Health Partner program received additional grant funds that facilitated expansion into four additional counties with transportation issues, low socio-economic status, high rates of unemployment, increased infant mortality rates, and a lack of professional medical**

providers.//2010//

/2009/ Promoting Safe and Stable Families (PSSF): The purpose of the PSSF is to enable Georgia to develop, establish, expand and/or operate coordinated community-based supports and services for children and families to: 1) prevent child maltreatment among families at risk through the provision of supportive family services; 2) assure children's safety within the home and preserve intact families in which children have been maltreated, when the family's problems can be effectively addressed; 3) address the problems of families whose children may have been placed in foster care so that reunification may occur in a safe, stable, and timely manner; and 4) support adoptive families by providing the necessary support services so that they can make a lifelong commitment to their children. Since 1996, the PSSF program has been administered by the DHR Division of Family and Children Services. Beginning July 1, 2008, the program will be administered by DPH.//2009//

Reducing Sudden Infant Death Syndrome: FHB contracted with The First Candle/Sudden Infant Death Syndrome Alliance, Inc. to pilot a SIDS reduction program in an African American community with the highest incidence of SIDS and Other Infant Deaths (OID) and to reduce infant mortality and family morbidity due to SIDS and OID through risk reduction and bereavement support to families who experience the loss of an infant. /2007/ A new RFP is being developed to secure a vendor to conduct a needs assessment and design targeted prevention strategies. Ongoing training and TA are provided to local public health staff, DFCS, Child Fatality Review Committees, law enforcement, medical examiners, and coroners.//2007// /2008/ SIDS risk reduction measures, such as the Crib Matching Program, have been developed as a resource to families at highest risk. Training on SIDS and other sleep related death is incorporated within this initiative.//2008// /2009/ OBO is continuing its statewide Crib Matching Program and SIDS/Other Sleep Related Deaths Education training. In addition, OBO will produce a SIDS Photonovela (picture book) in efforts to educate at-risk families, particularly African American families, and serve as a resource for SIDS/Other Sleep Related Deaths information.//2009//

School Health: Public Health funds school health programs in five health districts covering 18 counties. The Program offers TA, training support, and consultation to county health departments, professional school nurses, and other stakeholders for the development and implementation of coordinated school health programs. /2007/ Through a contract with the Georgia Cooperative Health Extension Program, the School Health Program conducted train-the-trainer workshops for hearing, vision, dental, and scoliosis screening. A statewide audit of kindergarten school records that evaluated use of the Certificate of Eye, Ear and Dental Examinations at school entry was completed, data has been analyzed, and a draft report is being developed.//2008/ DPH continues to fund school health programs in the five health districts as well as a full-time state level coordinator. Consultation and TA is provided to local school nurse programs and public health departments on immunization requirements, chronic disease management, emergency preparedness, and mandated screening requirements. //2008// /2009/ Final reviews are in process for the Vision and Hearing Screening Guidelines for Children. OBO staff continue to participate on the Nutrition and Physical Activity Workgroup and work is underway on the development of Healthy School Award criteria. Staff are also working with Children's Healthcare of Atlanta to develop a Georgia Child Health Report Card.//2009//

Social and Emotional Development in Young Children: FHB provided training on social and emotional development in young children to over 400 public health, early interventionists, MH/DD/AD, DFCS, Inclusion Specialists, Child Care Health Consultants, and DECAL staff. /2007/ FHB contracted with the Center for Child Well-being to provide social-emotional development in middle childhood training to child serving agencies throughout the state. Program development for home visiting training and model implementation for families at risk of child maltreatment is underway. //2007// /2008/ FHB contracted with the Center for Child Well-Being to provide training on social and emotional development in adolescents. BCW Skilled, Credentialed Early Intervention's Higher Education Institute "Issues in Early Social-Emotional Development" training was completed in July 2006, with over 80 participants.//2008// /2009/ "Promoting Social

and Emotional Development in Adolescence: Public Health Prevention" conferences were held in Fall 2007 in Decatur, Gainesville, Savannah, and Macon. The Center for Child Well Being trained a total of 305 participants on social and emotional development in adolescents and on the use of the 40 Developmental Assets of Adolescence and Bright Futures materials to promote the social and emotional development of youth. //2009// ***/2010/ ECCS funding has supported Center for Child Well Being training. ECCS recently received funding for a new three-year period. Grant activities will focus on social emotional development of young children, including the identification of early childhood social emotional resources, gaps, and barriers in Georgia; identification, development, and implementation of early childhood policies and strategies, with an emphasis on social emotional competence and well-being; development of an evidence-based/best practice universal developmental screening plan; identification of strategies/resources to finance universal development screening; increased training around developmental screening; and implementation of evidence-based/best practice universal developmental screening./2010/***

/2009/ Targeted Case Management: The Center for Medicaid Services (CMS) has changed the rules related to various Targeted Case Management (TCM) programs. The changes will result in the elimination of two TCM programs: Child Protective Services (DHR/DFCS) and Children at Risk of Incarceration (DJJ). In addition, five DHR programs must be modified to comply with federal regulations: Perinatal Case Management (DPH), Early Intervention Case Management (DPH), Case Management Support Coordination (MHDDAD) (service is being phased out with new MR waiver implementation), Adult Protective Services (Division of Aging), and Adults with AIDS (DPH). DPH has designated staff, including OBO personnel, to work with DCH Medicaid Assistance to address the impact of the new Medicaid rules on each of these programs.//2009// ***/2010/ CMS postponed planned rule changes related to TCM programs. Perinatal Case Management (PCM) and Early Intervention Case Management continue to be provided in varying degrees by county health departments. Medicaid Care Management Organizations (CMOs) have begun to recognize that the case management services that they are able to provide may not be adequate and that some populations could be better served by face-to-face local services that county health departments could provide. A survey conducted in April 2009 indicated 107 county health departments (67%) still have the capacity to provide PCM. In Spring 2009, DCH invited DPH to join in an exercise called Rapid Process Improvement (RPI) to work toward improving the increasing rates of late entry into prenatal care for pregnant women./2010/***

Tobacco Use Prevention and Cessation: Georgia's public health districts have established community-based tobacco prevention coalitions and implemented prevention and cessation activities, with a focus on youth. The QUIT LINE serves youth 13-17 years of age as well as adults 18 and older. /2009/ Current activities to reduce tobacco use in Georgia include: 1) enforcement of the Georgia Smokefree Air Act of 2005 designed to eliminate exposure to secondhand smoke in most public places; 2) promotion of the Georgia Tobacco Quit Line to Georgians 13 years of age and older; 3) promotion of tobacco-free school policies in all 181 school districts in Georgia designed to prevent youth initiation and promote tobacco cessation; and 4) implementation of activities to help eliminate tobacco-related disparities in four targeted health districts with above average adult smoking prevalence.//2009// ***/2010/ Cigarette smoking remains a leading preventable cause of illness and death in Georgia. Over 10,000 adult Georgians die from smoking-related diseases annually. About 35 infants die every year because their mothers smoked during pregnancy. DPH's Tobacco Use Prevention Program (TUPP) has adopted the national philosophy of changing environmental factors and health care systems to reduce tobacco use. Program initiatives include the Tobacco Free School(s) Movement, Georgia Tobacco Quit Line, Disparities Pilot Project, and Cancer Survivorship Project./2010/***

/2010/ Additional MCH programs and services descriptions can be found at <http://health.state.ga.us/programs/family/index.asp>. /2010/

B. Agency Capacity

/2010/ Effective July 1, 2009, DPH, including MCH (formerly FHB), moved to the Department of Community Health (DCH). See attached organization charts for new agency structure./2010//

The Family Health Branch (FHB), part of the Division of Public Health (DPH), Department of Human Resources (DHR), is Georgia's Title V Agency. The charge of the Branch is promoting the health of the state's mothers and infants, women of childbearing age, children and adolescents, and children with special health care needs. The Branch works toward: 1) early and comprehensive health services to women of childbearing age and their infants in an environment that fosters personal dignity; 2) timely and comprehensive health services to children which promote the optimal attainment of their individual abilities; and 3) comprehensive health and youth development services to adolescents in an environment that fosters personal responsibility and promotes positive health behavior. To carry out these responsibilities, FHB develops policy and conducts planning, oversees the operations of various MCH programs in local health departments and other organizations, collaborates with community partners to implement best and promising practices, and provides technical assistance and training./2009/ Effective 2/1/08, DPH restructured using a functional model to better align its human and financial resources. The new model groups similar tasks and expertise so that work can be performed more efficiently and collaboratively at the state office in order to better support public health at the local level. There are four major functional areas: 1) operations, 2) financial and administrative, 3) health information, policy, strategy and accountability, and 4) district operations. Operations has been organized into four offices focused on DPH's prevention priorities: 1) Birth Outcomes, 2) Healthy Behaviors, 3) Protection and Safety, and 4) Essential Preventive Clinical Services.

FHB's Infant and Child Health, Children with Special Needs, Women's Health, Oral Health, and Nutrition Programs are now located in Operations' Office of Birth Outcomes (OBO). OBO is organized to improve birth outcomes and focus on issues such as pre-term birth, low birth weight, infant mortality, and child morbidity. OBO, which includes Family/Community Support Services, Population-based Services, and Capacity Building, works to improve health outcomes by reducing risk factors and unhealthy behaviors that lead to poor health, and creating environments that lead to poor health, and creating environments that support healthy lifestyles.

Office of Healthy Behavior (OHB) sections include Youth Development, Health Promotion, and Health Communication. The Office of Protection and Safety, which includes Emergency Preparedness, EMS, and Trauma; Environmental Health, Injury, and Lead; and Public Health Laboratory, is responsible for leveraging the collective work of DPH's existing health protection functions. The Office of Essential Preventive Clinical Services is the intervention component of the work to achieve DPH's prevention priority areas through a clinical presence. It includes Communicable Diseases, Immunization, Screening and Treatment, Pharmacy, and Nursing Services.

For each of these four Operations areas, work across organizational lines, partnership with local public health and support from the other areas of the division are essential as DPH works on six focus areas: three risk behaviors (smoking, obesity, and substance abuse) and three health outcomes (infant mortality, cardiovascular deaths, and other premature death).

The Office of Budget, Finance, and Grants provides support for the development and monitoring of budgets and grants. The Office of Administrative and Support Services provides personnel, purchasing, invoice processing and asset accountability to the state office, districts and local boards of health. The Office of Insurance and Contract Management administers the Babies Born Healthy and Cancer State AID programs. The Office of Information Technology establishes and directs long term goals and strategies related to IT hardware, systems, and support.

The Health Information, Policy, Strategy and Accountability Team is charged with helping the

public health system focus on unmet needs. The team consists of four offices. The Office of Policy and Legislative Management aligns policy, legislation and appropriation at both the state and federal levels. The Office of Strategy and Systems Development coordinates the development and implementation of evidence-based best practices, key strategies and partnerships. The Office of Training and Workforce Development addresses training, education, and workforce development needs at the state, district, and local levels. The Office of Epidemiology, Evaluation, and Health Information (OEEHI) is charged with identifying unmet health needs, supporting DPH priority setting, resource allocation and evaluating the impact of public health's programs on the improvements in health status at both the state and local levels. OEEHI has four sections: Epidemiology, Evaluating and Reporting, Vital Records, and Health Information Systems section.

OEEHI's Health Planning and Assessment Unit (HPAU) creates infrastructure, design of information interfaces, and analysis that enable multi-level, including sub-county, health status assessment and local strategic health planning. HPAU designed and created the DPH's Online Analytical Statistical Information System (OASIS), an interactive data-reporting and mapping tool which serves as a one-stop shop for public health statistics and maps (<http://oasis.state.ga.us>). In 2007, the OASIS Web Query Tool provided on average ~400 data requests daily, mostly to local health professionals and the public. OASIS provides maternal and child health, chronic disease, infectious disease, mortality and morbidity, behavioral and socio-economic indicators. The OASIS Mapping Tool is updated with the latest vital records, hospital discharge, and cancer registry data available. The OASIS Web Query Tool's Infant Deaths Web Query, Perinatal Periods of Risk, Perinatal Deaths, and Perinatal Mortality Rates measures have been updated with the latest cohort of year of data available. In addition, all measures found in the Infant Deaths Web Query are now available by perinatal region (and the counties within), in addition to the standard public health district, country, state, and demographic profile geographies.

The standardized health data repository used by OASIS is currently populated with Vital Statistics (births, deaths, infant deaths, fetal deaths, induced terminations), Georgia Comprehensive Cancer Registry, Hospital Discharge, Arboviral Surveillance, Risk Behavior Surveys (Youth Risk Behavior Survey and Behavioral Risk Factor Surveillance Survey), and population data. OASIS tools can be used to develop profiles and report cards for counties or districts; assess community health needs, prioritize health problems, and evaluation programs; assemble data for grant writing, health analysis, special projects, or state legislative reporting; examine data by census tract to identify high risk populations and allocate resources; identify areas that contribute a disproportionate share of a health issues; target problem areas to analyze specific health problems and outcomes; create a basis for health communications or health advocacy; or map geographic areas to compare varied health outcomes.

OBO and DCH representatives have met to identify OBO data needs. A list of DCH data that OBO needs or wants access to has been developed, categorized by federal (block grant) requirements, state requirements, and a general "wish" list. DCH and OBO have agreed to develop an interagency agreement to provide at a minimum, data to meet the federal and state requirements.//2009// MCH and DCH representatives have continued to work together. It is anticipated that MCH's recent move to DCH will facilitate data efforts.//2010//

STATE STATUTES RELEVANT TO TITLE V PROGRAM: *The mission of Public Health in Georgia is to promote and protect the health of Georgians. The Official Code of Georgia (31-2-1 and 31-3-5) supports this mission by empowering DHR and the local county Boards of Health to employ all legal means to promote the health of the people. County Boards of Health develop and establish community-based systems for preventive and primary care services for pregnant women, mothers and infants, children and adolescents through local planning, direct provision of services and collaboration. Other relevant state statutes include: Newborn Metabolic -- O.C.G.A. 31-12-6 and 31-12-7; Well Child -- O.C.G.A. 31-12-6 and 31-12-7; UNHS -- O.C.G.A. 31-1-1-3.2; School Health -- O.C.G.A. 20-2-771.2; Children 1st -- O.C.G.A. 31-12-6, 31-12-7, 31-1-3.2; Babies Can't Wait -- O.C.G.A. 31-1-3; Babies Born*

Healthy -- O.C.G.A. 31-1-3.2; Family Planning -- O.C.G.A. 49-7-03; and Perinatal Case Management -- 31-2-2. /2010/ See HB 228 below. DCH is now the legal state entity, empowered along with local Boards of Health to promote the health of the people./2010//

/2007/ House Resolution 518 created the House Study Committee on Children: Newborns to Age Five, which was charged with a study of the conditions, needs, issues, and problems of children, newborns to age five. House Resolution 1079, passed in 2006, created the House Study Committee on the Creation of a Children's Budget to study issues surrounding the feasibility and usefulness of a resource that would identify all programs, sources of funding in state budget and trends in children's outcomes related to their safety, welfare, and education to determine legislative action should be recommended. House Resolution 1663 created the House Study Committee on Public Health to identify the mission statement of the state with respect to public health, review the current grant-in-aid funding formula, examine the uses of current funding, identify local public health needs, and address other related issues to determine whether any of these issues warrant being addressed through legislation. House Bill 1066 authorized DHR to establish newborn screening fees to help defray costs incurred by the department. Senate Bill 529 (Georgia Security and Immigration Compliance Act), requires verification that adults seeking many state-administered benefits, such as non-emergency medical care and unemployment benefits, are in the country legally. It would also sanction employers who knowingly hire illegal immigrants.//2007// /2008/ The 2007 Legislature passed HB 429 which requires Georgia physicians to offer opt-out HIV testing to pregnant women. It also requires doctors to refer women identified as positive to counseling and medical services. HB 655 establishes a Georgia Commission on Hearing Impaired. SB 529, the Georgia Immigration Act of 2006, becomes law on July 1, 2007. It requires, with certain exemptions that immigrants over the age of 18 present verification of lawful presence in the U.S. when applying for state, local, or federal benefits. Verification of legal status is not required for services related to children under 18, emergency medical conditions and disaster relief, immunizations for vaccine-preventable diseases, communicable diseases, prenatal care, federally funded programs which prohibit exclusion of services and/or verification of citizenship (WIC and Title X Family Planning programs), and medical and public health services delivered in-kind at the community level without regard to recipient income that are necessary for protection of life and safety. //2008// /2009/ HR 1275 created a study committee to conduct a study of the conditions, needs, issues, and problems associated with Sickle Cell anemia and recommend any needed actions or legislation. SB 507 established basic requirements for basic therapy services for children with disabilities detected under screening activities required by federal law. In January 2008, Governor Perdue appointed a special committee to craft a plan to restructure DHR. The committee is reviewing options, including combining, consolidating, or separating DHR's four divisions (DFCS, DPH, OAS, and MHDDAD). Recommendations will be made to the Governor and General Assembly in summer 2008.//2009// ***/2010/ HB 228, passed by the 2009 Georgia General Assembly, reorganizes DHR and the Department of Community Health (DCH) and creates a new Department of Behavioral Health and Developmental Disabilities (DBHDD). Under the legislation, DCH was reorganized effective July 1, 2009 to include all of DHR's public health and long term care regulation programs.(See attached DCH organizational table.) This reorganization will streamline the state's health-related activities which currently reside in two separate departments. The reorganized DCH is led by the current DCH commissioner, Dr. Rhonda Medows. Aging, the Division of Family and Children Services, and Child Support are now located in the Department of Human Services with Commissioner B.J. Walker heading the Department. The new DBHDD is responsible for all mental health, addictive disease, and developmental disability programs that were formerly under DHR. Dr. Frank Shelp serves as the new agency's commissioner./2010//***

Two governing bodies, the Board of Human Resources and the county boards of health, have key oversight and regulatory responsibilities. The State Board of Human Resources' 15 members are appointed by the Governor and confirmed by the Senate for staggered five-year terms. Seven members of the board must be professionally engaged in rendering health services, and at least five of those seven must be licensed to practice medicine in Georgia. The Board establishes the

general policy to be followed by DHR, makes budget recommendations, and appoints the commissioner. At the county level, boards of health, each with seven members, are required by state statute. These boards oversee the activities and budgets of the local public health departments and have regulatory and enforcement powers.

Georgia law permits the establishment of administrative multi-county health districts with the consent of county governments and boards of health in the counties involved. Two of the state's 19 health districts were merged in 2004. The current 18 public health districts range in size from one to 16 counties. Each district has a health director, appointed by the DHR Commissioner and approved by the boards of health of the concerned counties. Typically, each district health office is staffed by a health director (a physician), administrator, program manager, community epidemiologist, chief of nursing, environmentalist, and program and support staff. District health offices are located in the "lead" county of the district, usually the largest county in population. Local level responsibilities are set forth in county Grant-in-Aid contracts which describe programmatic activities and provide financial support to carry them out.

Direct services are provided by the county health departments, which are Medicaid providers of Health Check, Family Planning, Perinatal Case Management, Pregnancy Related Services, and Diagnostic Screening Services and Prevention Services (DSPS) Option. Funds to support county health departments come from fees, state Grant-in-Aid, county taxes and grants.

CAPACITY TO PROVIDE TITLE V SERVICES: FHB's capacity to provide: 1) preventive and primary care services for pregnant women, mothers, and infants; 2) preventive and primary care services for children and adolescents; and 3) services for children with special health care needs; 4) rehabilitation services for blind and disabled children under the age of 16 receiving benefits under Title XVI; and 5) family-centered, community-based, coordinated care including care coordination services for children with special health care needs and facilitate development of community-based systems of services for such children and their families is described in a matrix (see appendices) **/2010/ Effective July 1, 2009, OBO (formerly FHB) is now the Office of Maternal and Child Health./2010//**

Infant and Child Health (ICH) provides leadership and resources to communities in the development of a comprehensive system of care designed to improve the health and well being of infants and children and their families. ICH has directed its efforts in six areas: 1) Metabolic/Hemoglobinopathy Newborn Screening; 2) Universal Newborn Hearing Screening and Intervention, 3) Child Health Integration/Children1st; 4) School Health; 5) Bright Futures/Developmental Screens; and 6) Foster Care. /2007 A Newborn Surveillance and Tracking System is being developed to ensure newborn metabolic and hearing screening results are accessible to health providers and assure families are connected with necessary follow-up services //2007// /2008/ ICH continues to partner with GA-AAP and GAFP to promote child development and use of standardized developmental screening tools with private physicians. DPH supported the Immunization Program's changes to the immunization rules and regulations for children to attend schools and childcare facilities in Georgia. CMS is working with School Health on a logic model and revision of the school screening form 3300 (vision, hearing, dental, and nutrition). //2008// /2009/The ICH program, now designated Comprehensive Child Health Services, is located in OBO's Family and Community Services.//2009// /Comprehensive Child Health Services moved to DCH effective July 1, 2009 along with other MCH programs./2010// **Adolescent Health and Youth Development (AHYD) enhances the skills and improves the health status of Georgia's adolescents through opportunities and programs developed in collaboration with families, communities, schools, and other public and private organizations throughout Georgia. AHYD programs and services provide a network of community-based support to help adolescents succeed as they move into adulthood by focusing on the "assets" of individual youth and their families. AHYD funds a comprehensive network of district programs and services through four initiatives: 1) district youth development program coordination (monitoring and assessing health status of adolescents); 2) outreach program (direct Medicaid and PeachCare access for**

uninsured adolescents); 3) adolescent health program and community partnerships (mobilizing youth and community partnerships); and adolescent health centers (direct health care access for at-risk adolescents and their families). The Rape Prevention and Education program is also located in AHYD. /2007/ The Rape Prevention Education Program (RPE) transitioned back to FHB from DFCS in November 2005.//2007// /2008/ The first edition of the Teen Center Requirements and Procedures Manual has been drafted, with edits and input from AHYD's medical consultant. AHYD has also collaborated with ICH to standardize implementation of Bright Futures assessment in the state's 31 Teen Centers.//2008// /2009/ Under the DPH reorganization, AHYD services have been divided between OBO and the Office of Healthy Behaviors.//2009// /2010/ AHYD now lies completely within DPH's Office of Health Promotion and Disease Prevention. The Office moved to DCH effective July 2009.//2010//

Children with Special Needs (CSN) direct service delivery components include Babies Can't Wait (Georgia's Part C, IDEA comprehensive, coordinated, statewide interagency service delivery system for infants and toddlers, birth to age three, who have developmental delays or disabilities and their families); Children's Medical Services (Georgia's Title V CSHCN Program that provides or coordinates specialty medical evaluations and treatment for eligible children birth to age 21 with chronic medical conditions); and High Risk Infant Follow-Up (provides services to infants, birth to age one who are at increased risk for health and developmental delays due to medical conditions at birth). CSN provides program development, leadership, guidance, and resources to Georgia's 18 health districts in the development and provision of a comprehensive, integrated, and coordinated system of services for children with special needs, birth to age 21 and their families. Children1st, as the single point of entry, assures that families with special needs children are referred to CSN and their families get access to timely, community-based services, and monitors the at-risk population. Training has been provided on the social and emotional development of young children, practices to support inclusion of children with special needs in child care, leadership for CSN program managers, and interventions for children with hearing loss. CSN has collaborated with ICH and DFCS to support CAPTA requirements for referral of all children under age three with substantiated cases of abuse/neglect to BCW. CSN staff have also participated on the State Advisory Committee for Newborn Hearing Screening and a DECAL project to develop Georgia Early Learning Standards for children birth through three. CSN and the Georgia Chapters of the AAP and AFP have collaborated to promote the importance of developmental screening, early identification, and early intervention. /2007/ HRIFU and BCW have focused on increasing enrollment. //2007// /2008/ CSN programs (BCW and High Risk Infant) have worked to streamline internal processes by combining district Grant-in-Aid (GIA) contracts with other MCH programs serving the birth to age five populations and combining GIA for Title V CSHCN and genetics (effective July 1, 2007). //2008/ /2009/ CSN, now known as Children and Youth with Special Needs, is located in OBO. BCW redesign, initiated in 2007, continues as part of implementation of the new Birth to Five system//2009// **/2010/ Children's Medical Services has implemented a statewide initiative to establish a family support/advocacy group in each of the CMS programs in the 18 health districts. These groups will give families of children and youth with special needs the opportunity to advise CMS of needs/concerns and network with other families. Community involvement and awareness also will be encouraged. CSN is now located along with other MCH programs in DCH.//2010//**

Women's Health -- Programs include: Family Planning and Perinatal Health, including Babies Born Healthy, Perinatal Case Management (PCM), Pregnancy Related Services (PRS), six Regional Perinatal Centers, Perinatal Planning, Perinatal Health Partners, and Perinatal Outreach Workers. /2007/ Women's Health is updating the core requirements for tertiary centers and developing performance based models for family planning services.//2007// /2008/ Local boards of health continue to educate women about PCM and are able to conduct the initial assessment. Women's Health is also providing TA to district coordinators in implementing their family planning work plans, which include initiation of best practices, identification and removal of barriers to care, increased community awareness, and partnering with other agencies. Training has been provided

to 187 family planning staff across the state using March of Dimes Preconception Health modules. Along with the Office of Nutrition, Women's Health piloted an initiative to folic acid supplements and education materials on folic acid to all family planning clients. They also worked with district staff to partner with three CMOs in the provision of family planning services.//2008// /2009/ Women's Health and Perinatal Services are located in the OBO's Family and Community Support Unit. An issue paper, "Is Georgia's Commitment to Healthy Childbearing Flagging? Enhanced Family Planning Services May Be An Answer," has been developed on behalf of the Women's Policy Group. A group of stakeholders is gathering information to support a cost neutral Family Planning Medicaid Waiver.//2009// ***/2010/ Through a contract with Emory University, Women's Health adopted a preconception tool kit ("Every Woman, Every Time") which is being disseminated to women's health providers statewide. In collaboration with GAFF, community training is being provided on preconception care. In December 2008, MCH conducted a Summit on Infant Mortality which brought together traditional and on-traditional stakeholders to discuss emergency trends and identify strategies to decrease Georgia's infant mortality rates. Meetings are underway to discuss a cost neutral Family Planning waiver following DPH's move to DCH effective July 1, 2009//2010//***

Oral Health and Nutrition support all four population teams. /2009/ Oral Health provides school-linked dental prevention programs targeting high-risk elementary school children. Services include fluoride rinse and varnish, dental sealants, prevention education and treatment services (cleanings, fillings, crowns, and minor oral surgeries) at 46 fixed clinics and 12 mobile units located throughout the state. GOPH also provides water fluoridation and monitoring of community water systems through a contract with the Georgia Rural Water Association. Major initiatives include: 1) institution of a Monitoring and Surveillance Plan that includes the Georgia 3rd Grade and Head Start surveys as regularly occurring events on a 3-year cycle, as well as inclusion of Oral Health questions in national surveys such as PRAMS and YRBS; 2) training for Georgia medical and dental professionals on conducting oral assessments and fluoride varnish applications for very young children starting at age 6 months; 3) collaborative partner activities that strengthen infrastructure including reviving the Georgia Oral Health Coalition; and 4) expansion of programs that bring dental providers to rural public health facilities. //2009// /2009/ Oral Health provides school-linked dental prevention programs targeting high-risk elementary school children. Services include fluoride rinse and varnish, dental sealants, prevention education and treatment services (cleanings, fillings, crowns, and minor oral surgeries) at 44 fixed clinics and 12 mobile units located throughout the state. GOPH also provides water fluoridation and monitoring of community water systems through a contract with the Georgia Rural Water Association. Major initiatives include institution of a Monitoring and Surveillance Plan that includes the Georgia 3rd Grade and Head Start surveys as regularly occurring events on a 3-year cycle, as well as inclusion of Oral Health questions in national surveys.//2010//

Nutrition responsibilities include: 1) promotion of statewide population-based nutrition services; 2) integration and coordination of MCH and WIC Nutrition Services; 3) coordination with the four FHB population team groups to assure that nutrition is integrated into program initiatives; 4) development of a district infrastructure that increases access to high-quality nutrition care; and 5) partnerships to address emerging health issues such as obesity, breastfeeding, healthy eating, and physical inactivity. Major initiatives have included: 1) development and implementation of Georgia's Nutrition and Physical Activity Plan; 2) development of the 2005 Overweight and Obesity Report for Georgia; 3) a nutrition education evaluation and assessment of nutrition services delivered throughout Georgia in local agency WIC clinics; 4) partnering with Oral Health to train professionals to collect height and weight measurements for a representative sample of 3rd graders throughout Georgia to obtain a baseline of body mass index values; 5) completion of WIC programs reviews for local agency monitoring and continuous quality improvement for provision of feedback on infrastructure development; and 6) initiation of three breastfeeding initiatives using the Loving Support Campaign: Building a Breastfeeding Friendly Community, Educating Physicians in Their Community, and a

Breastfeeding Peer Counselor Program. /2008/ 2007 initiatives include the development of the 2006 Georgia Physical Activity Surveillance Report, management of the ADA accredited dietetic internship program, and planning and preliminary implementation of the preconception health and care initiative. The PH Dietetic Internship Program graduated 15 interns in 2006. To date, 133 public health nutritionists have graduated from the program. Nutrition and WIC are coordinating the Value Enhanced Nutrition Assessment (VENA) initiative.//2008// /2009/ Oral Health and Nutrition are located in OBO's Population-based Services.//2009// /2010/ The Office Nutrition continues to work with the Oral Health Coalition, providing technical assistance on collaborative efforts to promote the combined effect of good oral and nutrition practices. Nutrition has also spearheaded revisions of form 3300, which is designed to document nutrition, oral, hearing, and vision screenings of children entering Georgia schools. The revised form will provide needed nutrition and physical-activity related surveillance data that subsequently will be used for program development and information dissemination. In addition, WIC Food Packages have been updated to reflect current and relevant nutrition science recommendations regarding healthy eating habits. The Office of Nutrition also has been integrally involved in updating WIC nutrition assessment forms to include electronic data collection fields to enhance nutrition and physical activity behavior surveillance among program participants. Work has been conducted to implement a statewide online nutrition education program for all Georgia WIC participants that will increase nutrition education accessibility for Georgia's maternal and child populations.//2010//

BUILDING MCH CULTURAL AND LINGUISTIC COMPETENCY: Many of the state's health districts have identified growing immigrant populations and increases in clients with limited English proficiency as emerging trends that are having an impact on delivery of family planning services in the districts. Latinos, primarily Mexicans, are the most rapidly growing minority group in Georgia. DHR is committed to ensuring that limited English proficient (LEP) and sensory impaired (SI) clients have meaningful access to all programs and activities conducted or supported by the department. The Limited English Proficient (LEP) and Sensory Impaired Client Services Program is located in DHR's Office of Policy and Government Services. A DHR LEP Task Force has been established and DPH representatives serve on the task force and have provided input to the Department's LEP manual

DHR's strategy for providing meaningful access for LEP and SI customers involves assessing language access needs statewide; recruiting and training "qualified" interpreters and bilingual staff; developing a centralized databank of language resources; translating vital forms and informational documents; forming partnerships with community groups for outreach and education; providing diversity training to DHR employees; and implementing a procedure for monitoring services and resolution of complaints. DHR also is working to reduce and eliminate access barriers that discourage the enrollment of all eligible program participants, including those in immigrant and mixed-status families. State and local public health staff, including the FHB, are also able to draw on several key cultural competency resources, including the DPH's State Refugee Resettlement and Health Programs, DPH's Office of Communication, and DCH's Office of Health Improvement, Minority Health. The Office of Communications has developed and widely disseminated a "Directory of Qualified Interpreters and Translators & Multi-Ethnic Community Resource Guide. The DHR website includes information on Georgia's Latino and multicultural communities and includes a calendar of events such as multicultural family fairs and conferences. Minority Health's Information Center has resource materials that focus on health issues relating to minority populations.

At the local level, public health districts efforts to meet the needs of their non-English speaking clients have included hiring bilingual staff and/or utilizing translators or interpreters, conducting staff cultural diversity training, using language assistance phone lines, special health fairs in collaboration with local churches and other community organizations, and offering forms and patient education materials in Spanish and other languages. Districts have also engaged in social marketing and outreach to inform non English speaking clients of available public health

services such as family planning, prenatal education classes, etc. /2008/ DPH employees attended a cultural competence training at Morehouse School of Medicine in May 2007. Training topics included understanding cultural diversity and health disparities in the U.S. and Georgia, key concepts of cultural competence, promoting a culturally competent public health and healthcare system, and culturally-centered strategic development and planning. Georgia's Minority Health Advisory Council is dedicated to improving the health of minority populations in the state. Twelve members were appointed in October 2006 to address health disparities and other health care concerns of Georgia's African American, Hispanic/Latino, Asian/Pacific Islander, and American Indian/Alaska Native populations. The Council is providing leadership in the development of a health care strategic plan that will address improvement in the health status of minority populations in Georgia.//2008//. /2009/ To provide meaningful access to services for LEP and sensory impaired (SI) customers, DHR service sites are required to have: 1) Notice of Free Interpretation Service Wall Poster prominently displayed in all reception and intake areas; 2) Notice/Policy of Nondiscrimination prominently displayed in all reception and intake areas; 3) the "I Speak" DHR card, which accommodates the identification of 38 languages likely to be encountered, accessible for DHR staff use; 4) State LEP/SI Plan and accompanying LEP/SI Policy and Procedures accessible for reference for all DHR staff; 5) LEP/SI Intake and Tracking Form, with instructions, accessible for DHR staff use; 6) "Waiver of Right to No-Cost Interpreter Services" form and Discrimination Complaint Form accessible for DHR staff use; 7) a sign posted identifying the Language Access Coordinator and Language Access Team Member for the Division or Office; 8) current listing of DHR Language Contractors, other contractors providing services, and contact information for a telephone interpretation service; 9) list of translated materials by title, date, form number, and language; 10) method of tracking the number of LEP/SI customers receiving services; 11) LEP/SI central file or appropriate alternative for paperless offices; 12) completed Local Language Access Plan; and 13) LEP/SI Reference Notebook (including items listed above) for use by staff, generally housed at the front desk.

State and local programs continue to translate and/or purchase relevant maternal and child materials. For example, Newborn Screening parent brochures have been translated into Spanish; UNHSI brochures are available in Spanish and Chinese. The UNHSI Resource Guide is also available in Spanish. All health districts are provided funding through Grant-in-Aid to cover the cost of language interpreters for families receiving hearing follow-up services.

Racial and ethnic minorities make up over one-third of Georgia's population, but their disease burden is significantly higher. The Georgia DCH Office of Health Improvement, Minority Health's recent publication, "Georgia Health Equity Initiative -- Health Disparities Report 2008: A County-Level at Health Outcomes for Minorities in Georgia," provides data and information to help providers and the public understand health disparities, identify gaps in health status, and target interventions in areas of greatest need. The report is the first of its kind to focus solely on minority health outcomes for each of Georgia's 159 counties."//2009//

/2010/ Over the past year, DHR remained committed to ensuring that limited English proficient (LEP) and sensory impairment (SI) individuals have meaningful access to all programs and activities conducted or supported by the department. As described above, services include programs and assistance provided by the department, its divisions and offices, as well as those funded by grant-in-aid resources to county, regional, and local offices. DHR's strategy for providing meaningful access for LEP and SI customers involves assessing language access needs statewide, recruiting interpreters and training bilingual staff; developing a centralized databank of language resources; translating vital forms and informational documents; forming partnerships with community groups for outreach and education; and implementing a procedure for monitoring services and resolution of complaints. DHR is also committed to reducing and eliminating access barriers that discourage the enrollment of all eligible program participants, including in immigrant and mixed status families.

The DHR web site includes information on the department's LEP and SI customer services,

including contact information, policies and procedures, service delivery checklist, forms and notices, Georgia demographics, and how to find an interpreter. DHR has developed several forms and client notices to assist DHR staff to better serve LEP and SI customers. All forms are available to DHR division and offices statewide and include a notice of free interpreter services, interpreter invoice, "I speak" care, Feedback -- Interpreter form, individual satisfaction survey, and DHR employee form. Forms and notices are available in Arabic, Chinese, English, French, German, Gujarathi, Hindi, Korean, Spanish, and Vietnamese. Links are provided to the Georgia Commission on Hearing Impaired and Deaf Persons, MLA Language Map, National Association of the Deaf, LEP, Ethnologue, and the American Foundation for the Blind. DCH shares DHR's commitment to meaningful access. The Office of Health Improvement, Minority Health is located within DCH. MCH will follow all DCH access guidelines and requirements. //2010//

BUILDING MCH COMPETENCIES: DPH offers state and local staff coordinated training and development activities to improve knowledge and job performance. DPH use of the DHR video interactive conferencing systems (VICS) is increasing local public health staff participation in coordinator meetings and trainings. /2008/ To increase and enhance the learning capacity and leadership skills of DHR employees, the FHB and Prevention Branches identified 25 DPH state and district program managers, section leaders, supervisors and future leaders to participate in a one-year pilot Executive Development Leadership Institute (EDLI). EDLI participants are required to complete a 360o Assessment and attend various trainings, including Effective Communication, Succession Planning, Collaborative Leadership, Cultural Competency, Balanced Scorecard, Performance Management, and EDLI Projects. Information sessions on the Balanced Score Card have been made available to all FHB staff. Training has also been provided on Strategic Performance Management Systems SPMS).//2008// /2009/DPH recently completed a one-year pilot of a leadership development program. OBO Senior Director Rosalyn Bacon conceived the idea of the program based on national models of public health leadership institutes across the U.S. DPH Office of Training and Workforce Development pilot leadership development program activities included learned sessions, a 360 degree feedback and coaching process, and year-end debriefing. The eight Leadership Competences included: Emergency Preparedness Leadership Academy, Effective Communication for Public Health Leaders, Succession Planning for the Leader, Collaborative Leadership-Building Relationships with Your Team, Systems Thinking, Performance Management Series, Cultural Competency, and Leading Challenge Through the Balanced Scorecard. In addition, DPH staff training has been provided on Setting Wildly Important Goals (WIG) and on the Performance Management Process. Training for supervisors has also been offered. VICS training on the 2007 Georgia Security and Immigration Compliance Act has been offered for state and local public health staff and sample/model forms that may be used for "Declaration of Citizenship or Legal Alien Status" have shared with districts.//2009// ***/2010/ Training at the state and local level continues. Staff education at the local level has included training on "Understanding and Implementing SB529 (verification of lawful presence in the U.S. for any person 18 years of age or older) and "Precautions to Avoid Civil Rights Violations." A train-the trainer workshop for public health districts and a self-paced training course for state office staff has been developed. Education materials have been revised to reflect changes DPH made in its guidance concerning immigrant access to public health services. Annual civil rights training is required for all WIC program employees, with a special focus on the specific components that WIC must address. //2010//***

BUILDING PUBLIC AWARENESS FOR MCH: a Communications Team works to facilitate continuous quality improvement relating to MCH publications, policy, and correspondence review and approval processes, effectiveness of meetings, health observance/ awareness initiatives, promotional materials development, language/translation issues, web enhancement and maintenance, and other communications issues. /2007/ A number of publications have been developed and dissemination, including Georgia's Family Planning Program -- Facts At A Glance Fiscal Year 2005, Middle Childhood: The Status of Georgia's Children Ages 5 through 9, English and Spanish Resource Guides for Families of Children with Hearing Loss, Obesity in Georgia's

3rd Grade Children, Suicide in Georgia, Georgia's 10-Year Nutrition and Physical Activity Plan, and Babies Can't Wait Part C Performance Plan. //2007// /2008/ Publications include the Live Healthy in Faith Toolkit; Obesity Program and Data Summary March 2007 School Health Profiles and Surveys Report; Plan Ahead for a Healthy Baby; Child Abuse Protocol; Home Safety Screen; Middle Childhood: The Status of Georgia's Children Ages 5 through 9; Georgia Newborn Screen Program Physician Pocket Reference; Revised Parent Brochure for Newborn Screening; Quick Reference to Newborn Screening Disorders; Helping Promote Healthy Brain Development by Better Brains for Babies chart; Report of Vision, Hearing, and Dental Screenings of Children Entering Georgia Public Schools, 2005; Babies Can't Wait Part C State Performance Plan; and Babies Can't Wait Part C Annual Performance Report.//2008// /2009/ Publications include "The Status of Oral Health in Georgia, 2007" report, "Men's Health Report," and the "Georgia Child Injury Prevention Plan". A new quarterly DPH Office of Nutrition electronic newsletter, "The Georgia Flavor," has been developed. The Spring Quarter 2008 issue, "Fruits & Veggies: Feeling Good and Eating More!" has been disseminated electronically to the 18 health district and to key stakeholders and partners. //2009// **/2010/ Publications include the Fall 2008 edition of the Office of Nutrition's quarterly newsletter, "The Georgia Flavor." The ECCS web-based clearinghouse (www.eccsga.org) is now live and over 200 summaries of early childhood web-based resources have been identified, summaries written, and information loaded on the site.**//2010//

C. Organizational Structure

The framework in which FHB functions is depicted in the attached organizational charts. DPH is part of the Georgia DHR superagency, which brings together family protective services, income maintenance, childcare, mental health/developmental disabilities/addictive diseases, and regulatory oversight services. DHR's four divisions are Aging Services, Public Health (DPH), Mental Health/Developmental Diseases/Addictive Diseases (MHDDAD), and Family and Children Services (DFCS). It also includes the Office of Regulatory Services, Office of Adoptions, and Office of Child Support Enforcement... Administrative and support functions, including human resources, information technology and budget and financial services, are consolidated at the departmental level. DPH has a staff of approximately 7,500 state and county public health employees, 18 health districts, and 159 county health departments that administer services that promote the health and well being of the whole community. County public health departments also offer direct healthcare to low-income people and people in underserved areas of the state, and work with private medical providers to assure these groups receive needed care. /2009/ In FY 07, DHR had 20,657 employees, 44 programs, and a budget of \$2.91 billion. DPH had 1,326 state employees, 5,444 county health department employees, 18 health districts, a budget of \$644.2 million, and more than 4 million customer visits a year. DPH's reorganization, depicted in the attached organizational charts, is described in Section B. Agency Capacity.//2009// **/2010/ As described in Section B. Agency Capacity, DPH, including MCH (formerly FHB), moved to the Department of Community Health effective July 1, 2009. In addition, a new department, the Department of Behavioral Health and Developmental Disabilities, has been created. A team of DPH and DCH staff have met over the past six months to plan for the transition.** //2010//

The DHR Commissioner is appointed by and accountable to the State Board of Human Resources. B.J. Walker has been the Commissioner since May 2004. The Board provides general oversight of DHR's activities by establishing policy, approving goals and objectives and other appropriate activities. Included in the Commissioner's office are the Assistant Commissioner for Special Projects; Office of the Assistant Commissioner for Policy and Government Services, which includes fraud and abuse, communications, legal services and constituent services; and the Offices of Planning and Budget Services, Financial Services, Technology and Support, Human Resource Management, Audits, Human Resource and Organizational Development, and Adoptions.

DPH, headed by Director Stuart T. Brown, M.D. since January 2005, is the designated state public health agency as well as the state agency for children with special health care needs. DPH branches include Family Health, Epidemiology, Prevention, Environmental Health, Chronic Disease Prevention and Health Promotion, the State Public Health Laboratory, and the Women, Infants and Children Program (WIC). //2009/ Dr. Brown retired in April 2008. Sandra Ford, M.D., M.B.A. has been appointed Acting DPH Director. //2009//

Each DPH branch has responsibilities that inter-relate with MCH activities, requiring strong working relationships. //2007/ Control, EMS/Trauma Systems, Emergency Preparedness, Nursing, and Pharmacy. In December 2005, Sonia Alvarez-Robinson, MA became Director of the DPH Strategic Resource and Development, that includes the Office of Health Information and Policy, Office of Training and Workforce Development, Public Health Practice Group, Grants Activity, and Live Healthy Georgia Initiative. //2007// //2008/ // In June 2006, Janice Carson, M.D. joined DPH as Deputy Director for District Operations, providing oversight to the 18 public health districts in the state. In August 2006, Dr. Carson was given additional responsibility to provide oversight to the FHB, Epidemiology, Chronic Disease Prevention, WIC, Prevention, and Office of Nursing. She assumed responsibility for the Office of Prevention (Substance Abuse and Violence Prevention) in February 2007. Oversight of the FHB was transferred to Morris Govan in May 2007. //2008// //2009/ In 2007, Mr. Govan was appointed DPH Deputy Director of Operations. //2009//

Over the past five years, the state's public health environment has experienced a number of challenges, including budget cuts, a shift to Medicaid managed care and increasing Medicaid costs. As public health priorities are changing in Georgia, Public Health's role is shifting from a safety net role of categorical programs to a population-focused role. Major tasks include defining new staff roles and creating and supporting DPH's mission to provide leadership in: 1) describing the status of health in Georgia; 2) building coalitions to improve health conditions; and 3) identifying new ways to prevent illness and injury through assessment of health problems, assuring healthy conditions and linking people to health care services.

The FHB Director, Rosalyn K. Bacon, M.P.H., provides leadership and vision for the Branch. She directs and oversees the overall FHB administration, serves as the lead staff person for "family health" policy development for the Division, and is responsible for developing and implementing a marketing and public relations plan that incorporates both internal and external strategies. She also has the chief responsibility for advocacy of the Branch and its programs and services throughout Georgia's MCH system. //2009/As part of DPH's reorganization (see B. Agency Capacity), Ms. Bacon was appointed Senior Director of the new Office of Birth Outcomes in late 2007.// **//2010/ OBO became the Office of Maternal and Child Health effective July 1, 2009. It is now located, along with other DPH programs, in DCH. See attached organizational charts and Section B. Agency Capacity for additional information.//2010//**

Financial and personnel functions are centralized in the FHB Operations Section, which provides oversight of daily operations and administration, contracts, management of human resources/personnel and employee relations. Operations is comprised of two offices, the Office of Administrative Support (OAS) and the Office of Contract Management and Compliance (OCMC). OAS is responsible for reviewing and revising all aspects of the existing financial reporting system, organizing and formalizing budget procedures in all FHB programs, implementing a budget information database, ensuring FHB contracts comply with state and federal regulatory requirements and internal quality control and compliance measures, and working closely with FHB program staff to develop budgets for grant applications. OAS serves as the liaison between the FHB, Division, and the Office of Planning and Budget Services in the DHR and is responsible for FHB human resources management and assists in the development of new positions and modification of existing positions. OAS screens and organizes the interview process for all Branch applicants and develops and implements a centralized orientation process for new hires.

OCMC is responsible for developing contractual relationships, implementing contract compliance, serving as the liaison between FHB, DPH and DHR's Offices of Contract Management and Audits, reviewing Independent Audit Reports of applicable FHB contractors; and performing programmatic audits of both Branch and contractual programs and services. A Systematic Integrated Financial System, accessible to FHB Population Team Leaders and Section Directors, provides an up-to-date financial information picture of the FHB's financial and human resources status. A grants database facilitates the grants management process and assures deadlines are met.

The Director of the Programs and Services Section is responsible for day-to-day program and services operations as well as direct supervision of the four Population Team Leaders. She also is responsible for providing leadership to the population-based work teams (e.g., assistance with the development of population-based work plans and the development and design of new and revised programs and services.)

The Program and Services Section assures implementation, collaboration and integration of programs and services within the Branch. Leadership has been provided for integrated MCH site visits.

The Programs and Services Section, in collaboration with PPE and DPH legal staff, works to provide leadership to a cross-division work team on implementation of the Women's Right to Know Act (HB 197). This legislation requires parental notification, provision of informational and resource materials, and physician web-based reporting. Unemancipated minors under the age of 18 seeking an abortion must either be accompanied by a parent or guardian who can show proper identification and a minor's parent or guardian must be notified in person, by telephone, or mail that the abortion is to be performed at least 24 hours prior to the procedure or physician's agent can give written notice of the pending abortion sent by certified mail with return receipt required to parent or guardian. Physicians must provide women considering abortion objective and medically accurate information 24 hours in advance of the procedure. After receiving information, women are required to wait 24 hours before proceeding with an abortion.

The Offices of Adolescent Health and Youth Development (AHYD), Children with Special Needs (CSN), Infant and Child Health (ICH), and Women's Health, described in III. B. Agency Capacity, are located in the Programs and Services Section. AHYD includes: 1) Comprehensive Adolescent Health Services; 2) Youth Development Program, 3) Outreach to Uninsured Youth, and the Violence Against Women Program. CSN includes: 1) Babies Can't Wait (BCW), 2) Children's Medical Services (CMS), 3) Genetic Services, and 4) High Risk Infant Follow Up. ICH includes: Children 1st, Universal Newborn Hearing Screening, School Health, Well Child Health Services, and SIDS. The Genetics program manager is located in ICH and works across the CSN and ICH population teams. Women's Health includes: 1) Maternal High Risk Services - Perinatal and Prenatal Care and Resource Mothers; 2) Reproductive Health Services - Family Planning and Preconceptional Health, 3) Preventive Women's Health Services, and 4) Men's Health Services. The Maternal Mental Health and Substance Abuse Prevention Specialist reports to the Programs and Services director and works across all sections and teams. /2008/ Language was revised in the Women's Right to Know Act , which offers women seeking an abortion the opportunity to have an ultrasound if equipment is available and to view and hear the fetal heartbeat with the option to opt-out. Voluntary or informed consent is required for abortion to be performed. The physician performing the abortion must inform the patient about medical assistance for prenatal and neonatal care and healthcare facilities that perform free ultrasounds. DHR is required to publish all information in English and other languages.//2008// /2009/ See Section B. Agency Capacity for reorganization update.//2009// /See attached organizational charts and Section B. Agency Capacity for information on MCH's transition to DCH July 2009.//

Programs and services are organized using the "population team" model, with population team leaders who function as program managers reporting to the Director of Program and Services. Medical Consultants provide medical oversight and consultation to the Director and the four

Population Teams. The Nutrition Section Director works closely with the FHB Section Directors and population teams (AHYD, ICH, Women's Health, and CSN) and State WIC Director to assure that nutrition is an integral component of the MCH system. The Oral Health Director also works with the FHB Section Directors in integrating oral health into components of the MCH system.

The Policy, Planning, and Evaluation Section (PPE) works closely with the Programs and Services Director to provide leadership to the Population Teams and Sections for priority setting, planning, and policy development. PPE provides leadership for cross Branch initiatives and activities including: 1) cultural competency; 2) family and community involvement; 3) state legislative session pre-briefing, and monitoring; 4) process evaluations; 5) needs assessment; 6) training development; and 7) health promotion/communications. /2009/ Under the DPH reorganization, PPE and Data Team activities have moved to OEEHI. See Section B. Agency Capacity.//2009//

The Data Team Leader has responsibility for branch-level data concerns, providing leadership and guidance to each of the Managers and the Data Analyst assigned to each of the four population teams; identifying baseline data and performance measures for services, and identifying outcome measures for MCH populations served. The Data Team collaborates with PPE to determine common areas of work and define the vision and practices necessary to support the FHB and MCH work in Georgia. Technical assistance is provided to the four MCH population teams to improve the way data is utilized for Branch decision-making.

/2007/ The FHB recognizes that Georgia's MCH system must be agile and responsive to the broader environmental changes that affect our system. Together with other DHR divisions, DPH is looking at ways to become better at achieving DHR's core purpose: to strengthen Georgia families. Internal challenges and desired outcomes have been identified. These challenges include the following: 1) accountability gaps persist; 2) technical assistance needs to be better coordinated, integrated and systematic; 3) quality assurance is random, not systematic and primarily reactive; 4) increased data for decision-making, planning and to develop a formalized system for monitoring performance; 5) improve internal efficiencies through a centralized system to support a performance management system; 6) opportunities exist to monitor and administer contract compliance more thoroughly; and 7) continuous learning and strong leadership (at all levels) is needed to achieve MCH goals. FHB restructuring is currently under way. For more information on FHB's restructuring, see page 115 of Georgia's FFY 2007 Needs Assessment Update (Section C of Georgia's FFY 2006 Needs Assessment document).//2007// **/2010/ DPH, including MCH, has transitioned to DCH effective July1, 2009.//2010//**

An attachment is included in this section.

D. Other MCH Capacity

Central and out-stationed staff providing administration, planning, evaluation, and data analysis capabilities as well as direct services are allocated as follows: Administration -- 17 central and 94 out-stationed staff; planning -- 5 central and 103 out-stationed; program support consultation -- 32 central and 0 out-stationed; evaluation -- 3 central and 10 out-stationed; data analysis --10.5 central and 12 out-stationed; and direct service -- 618 out-stationed. A description of FHB staff qualifications follows. /2007/ There are now 4 central staff in planning and 10 central in data analysis.//2007// /2008/ There have been no changes in staff allocations.//2008//

STAFF QUALIFICATIONS AND CAPABILITIES:

Rosalyn K. Bacon, M.P.H. is Director of the FHB and is responsible for the leadership and management of Titles V and X (MCH/CSHCN and Family Planning, respectively); IDEA, Part C; Preventive Health and Health Services Grant (Sexual Assault Prevention) and many other grants and state funds allocated to support the health and well being of children and their families. She also is responsible for strategic planning, policy development and implementation, and

programmatic leadership for MCH statewide. These programs provide a statewide system of prevention and intervention services provided by Georgia's 159 county health departments and over 200 healthcare agencies and/or community-based organizations. She received her B.S. in 1992 from Georgia State University, Atlanta, Georgia and M.P.H. in 1995 from the University of Alabama at Birmingham. /2009/ Ms. Bacon was appointed Senior Director of the Office of Birth Outcomes in late 2007. //2009// OBO, formerly FHB, is now the Office of Maternal and Child Health.//2010//

/2009/ Delores Anyaehie, M.S.N., F.N.P., B.C., is the Acting Program Manager of the Children's Medical Services Program. She received her Baccalaureate in Nursing from Tuskegee University in Alabama and her Masters of the Science of Nursing from the Medical College of Georgia. Ms. Anyaehie has over 15 years of experience in public health nursing in Georgia and over 20 years of experience as a board certified family nurse practitioner. //2009//

Monica L. Barnett is a Health Educator Consultant for the PPE Section in the FHB. She is the MCH Title V Block Grant Program Coordinator and DPH's Executive Development Leadership Institute (EDLI) Program Coordinator. Ms. Barnett received her M.S. in Health Promotion from the University of Mississippi in 2003.

/2010/ Lynn Campbell, R.N., M.P.M., formerly a Women's Health Coordinator, joined the State Family Planning Program in December 2008 as the Family Planning Program Manager. Ms. Campbell has over 31 years of experience in the healthcare industry. She has a B.S. Nursing degree and a Master's degree in Project Management. //2010//

/2009/ Elizabeth C. Lense, DDS, MSHA, the Georgia Oral Health Program Director, received her dental degree and completed a residency in Oral Maxillofacial Pathology at Emory University School of Dentistry, and went on to teach Oral Pathology at West Virginia University Schools of Medicine and Dentistry. After returning to Georgia, Dr. Lense taught Oral Histology and Embryology at Georgia Perimeter College School of Dental Hygiene, as well as served as a clinical instructor for oral diagnosis and radiology. While working as a dentist in the dental public health system, she received a Master's degree in Healthcare Administration from Georgia State University, and went on to serve as Director of the Pediatric Dental program for Grady Health System at Hughes Spalding Children's Hospital from 1999-2006. She is an Asst. Clinical Professor in the Dept of Pediatrics at Emory School of Medicine, and an adjunct instructor in Pediatrics for Morehouse School of Medicine. She has been on the Board of Directors of the Healthy Mothers, Healthy Babies Coalition since 2000, and served as both Vice-President and President. She is also a member of the Hispanic Health Coalition, Hispanic Dental Association, and the Georgia Dental Society. Dr. Lense completed a Fellowship in Public Health at the CDC Division of Oral Health and now serves as the Georgia's State Oral Health Director. She was recently appointed Section Chief of OBO's Family and Community Support Services.//2009//

/2009/ Abdul K. Lindsay MScFT, RD, LD, CPT is currently serving as the Chief Nutritionist for DPH. Mr. Lindsay has a Master's in Food Science Technology and a Bachelor's in Dietetics/Nutrition and Fitness from the University of Georgia (UGA) and Florida State University, respectively. Additionally, he is registered nationally and licensed as a Dietitian and within the State of Georgia. //2009//

/2009/ Sharon Quarry, MS received her Master of Science in Genetic Counseling in 1997 from Howard University, Washington, DC. She is currently the Newborn Screening Unit Manager, Office of Birth Outcomes, Division of Public Health, Department of Human Resources as well as a part time Senior Research Coordinator for the Division of Medical Genetics, Department of Human Genetics, Emory University. Ms. Quarry has over 9 years experience with Genetics. //2009//

/2010/ Sarah Rank, AuD, is the Coordinator for the Georgia Universal Newborn Hearing

Screening and Intervention (UNHSI) Program. She received her B.A. degree in Communication Sciences and Disorders from Radford University, Radford, Virginia and M.A. degree in Audiology from Northwestern University in Evanston, Illinois. Ms. Rank has earned a Doctoral degree in audiology and is licensed by the Georgia State Board of Examiners for Speech and Language Pathology and Audiology.//2010//

/2009/ Kelli E. Rayford, RN, MSN, PNP-BC is the Program Director for the Comprehensive Child Health Services Unit in the Office of Birth Outcomes. She has worked in various areas of Public Health for over 11 years, including positions as a Nurse Practitioner, Nurse Manager, and Nurse Consultant. In her current position, she has oversight of several Public Health programs and services, including Children 1st, Health Check, Integrated Family Support, and Promoting Safe and Stable Families.//2009//

Beverly Y. James Stanley, the Operations Director, has over 18 years of administrative experience acquired working in the governmental and private sectors. Prior to joining the FHB, she worked for DHR in the Office of Planning and Budget Services. She earned her B.A. in Human Resource Management at the University of South Carolina. /2009/ Ms. Stanley is now the OBO Project Director.//2009//

Daphne Terry, Ph.D., M.P.H., M.Ed. is the Children 1st Program Coordinator. Prior to joining CCHS, she worked with the BCW Program. She has also taught public school, been a parent advisor for families with children with sensory impairments, Head Start center manager, community health educator, and an adjunct faculty member. Dr. Terry holds a B.S. from Tulane University, M.Ed. from the University of Montevallo, a M.P.H. from the University of Alabama at Birmingham, and a Ph.D. from Auburn University. /2009/ Dr. Terry is now the Developmental Specialist for Comprehensive Child Health Services. //2009//

/2010/ Claudia Treadwell, RN, BSN, is the Nurse Consultant/Coordinator for the Perinatal HIV Transmission Prevention Program. She has over nine years experience in clinical public health nursing and over three years experience as a Registered Nurse Consultant. Ms. Treadwell received her B.S. in Nursing from Barry University, Miami, Florida.

Phyllis Turner, M.S., has served as the CYSN Interim Unit Manager over Babies Can't Wait, Children's Medical Services, and High Risk Infant Follow up Programs since December 2008. Ms. Turner is also the CSN Coordinator for Public Health District 4 in LaGrange, Georgia where she is responsible for daily operations of Birth to Five Program serving children with special needs in 12 counties. In addition, she has over 20 experience as the Babies Can't Wait Coordinator for the LaGrange Health District. Ms. Turner holds an M.S. degree in Family and Child Development from Auburn University and a B.A. degree in Psychology from LaGrange College.//2010//

/2009/ Carol Vasbinder, C.I.P.A., Operations Analyst II for the Office of Birth Outcomes and Project Coordinator for the MCH Block Grant. She began working for the Division of Public Health, Early Intervention Program in 1988, worked as an Operations Analyst I for Newborn Hearing Screening in 2001 and then as a Statistical Analyst II with the Family Health Branch Data Team in September, 2005. Now with the Office of Birth Outcomes, Ms. Vasbinder served as the SSDI Project Manager for Year 2 of SSDI and remains involved in a consulting capacity. //2009//

/2007/ Patricka D. Wood is the Perinatal Services Program Manager. She received her R.N. training from the University Hospital of the West Indies School of Nursing in Kingston, Jamaica. In 1983, she completed midwifery training at Foresterhill College, Aberdeen Maternity Hospital in Scotland. She received her M.P.H. from Emory University in 1995. She has been employed in high-risk maternal and infant care since 1983.//2007// Ms. Woods is the OBO Women's Health/Perinatal Services Program Manager.//2009//

Medical Oversight: To assure that FHB programs and services reflect sound clinical practice and medical research, the FHB has contracted with medical consultants to work with each of the four population teams in the Branch.

Family and community involvement: Families and community advocates played a vital role in providing local perspective and input into the state's FY 2006 MCH needs assessment. A total of eight focus groups were held statewide in urban and rural locations, comprised of a cross section of MCH stakeholders, providers, and consumers including parents of children with special needs, members of the Hispanic community, parent advocates, and teens. In addition, key informant interviews and web-based surveys were conducted that focused on needs, gaps, barriers, emerging issues, and what was working well in Georgia's MCH System.

Sixteen parent educators assist the BCW Program with policy, federal grant review, training and support for family members and providers, and encouragement of local and state parent involvement. All districts hold Annual Family Conferences for parents of children enrolled in BCW and CMS. A SIDS/Bereavement Specialist position is funded through First Candle/SIDS Alliance, Inc. to provide family-focused input to program planning and policy formation for all SIDS issues. In addition, several of the local level programs have integrated family involvement into their activities, i.e., Title X (Family Planning) District Community Advisory Committees, Nutrition peer counselors for breastfeeding, local Interagency Coordinating Councils (CCs) in all 18 Health Districts as part of the BCW Program. Parents of children in BCW and CMS participate in local ICC meetings and activities. Two parents of children who are hearing impaired are active members of the State Advisory Committee on Newborn Hearing Screening (SACHNS); they are also members of the SACNHS Executive Committee. In addition, through AHYD's network of 29 teen centers, families members have been engaged at all program levels, i.e., individual health care service planning for their children, advisory councils, volunteering and mentoring.

On August 1-3, 2005, Georgia Team attended the "Champions for Progress" meeting in Utah. The Champions for Progress Center provides leadership to support state and territorial Title V programs in the process of systems building at the state and community level for children and youth with special health care needs through a grant/contract from MHCB. The Georgia Team is developing a plan to increase and improve family participation for Georgia's families and children with special health care needs.

/2007/ In April 2006, a Head Start Oral Health Forum was held to obtain parent, teacher, and staff collaboration to create a Head Start Oral Health plan to increase access to prevention and treatment services. In addition, district oral disease prevention education and screenings of WIC clients includes parental involvement to facilitate access to care for young children. Oral Health collaboration with DECAL is also increasing parental involvement in children's oral health prevention activities.//2007// /2008/ Two parents of children with disabilities are currently appointed to the State Interagency Coordinating Council (ICC) for Early Intervention/BCW. A request for the appointment of five additional parents of children with disabilities has been submitted to the Governor's Office. Examples of CMS family involvement activities include participation in local ICCs; local Family Connection meetings; a legislative luncheon designed to educate legislators and Boards of Health members about public health services, including CMS services; Migrant Head Start Advisory Committee and Concerted Services and Head Start/Early Head Start Health Advisory Committee; Annual Parent Conference for the National Head Start Association. District CMS programs provide family members with financial support to assist with training, travel, child care or other related expenses. CMS staff also help families complete financial assistance applications to attend events and/or refer them to potential funding sources. A DHR team with representatives from DFCS, Division of Aging Services, Office of Child Support Services, MHDDAD, and DPH has been formed to assist grandparents raising grandchildren. Enhanced services for grandparents raising grandchildren, including providing multiple points of entry, have been identified. The UNHSI program collaborated with DOE and Georgia Parent Infant Network for Education (PINES) to host a family workshop for parents of children with hearing loss that provided information on parent advocacy, transitioning into the educational

setting, and parenting techniques for children with special healthcare needs.//2008//

/2009/ CMS continues to involve families in the development of client plans of care (POC) and needs lists. At the health district level, CMS staff attend and support Coordinating Councils, whose membership includes parent representatives. District staff also participate in local Family Connection initiatives and are involved with Head Start programs. Both initiatives have parent involvement. In addition, CMS district staff continue to support clients and their families in attending diabetes and asthma camps.

Parent representatives participate on the Newborn Screening Advisory Committee, which is currently chaired by a parent. Parents also serve on the Parent and Consumer Education Workgroup, including a parent who is the founder of the Save Babies Through Screening Foundation. A UNHSI Workgroup made up of parent representatives is being formed. One of the workgroup members is founder of the Georgia Chapter of Hands and Voices, a parent-driven, non-profit organization dedicated to providing support to families with children who are deaf or hard of hearing. Parents are sponsored to attend regional and national EHDI conferences. Funds are provided through UNHSI Grant-in-Aid to support the operation of community team meetings. Through the community teams, a resource list is developed to assist in linking families to local services.//2009//

/2010/ The State CMS Office has developed and is facilitating use of a family support group template. The hope is that each district CMS program will have a family support group for CMS or CYSN children and their families by 2010, with the ultimate goal of each public health district having a Family Action and Support Team. CMS continues to involve families in the development of client plans of care (POC) and needs lists. At the health district level, CMS staff attend and support Coordinating Councils, whose membership includes parent representatives. District staff also participate in local Family Connection Partnership initiatives and are involved with Head Start programs. Both initiatives have parent involvement. In addition, CMS district staff continue to support clients and their families through various methods, including providing diabetes and asthma camps, coordinating mothers' nights out, grandmother support groups, asthma coalitions, parent workshops, sickle cell training for school nurses, transition and resource fairs, teen transition groups, parent advisory committees, human rights committees, troubled children's council's, Head Start Advisory Committee, and other advisory committees and task forces.

A parent representative has been identified to participate on the NBS Hemoglobin Workgroup.//2010//

E. State Agency Coordination

Input from the broad array of public and private sector organizations is key in assisting with the State's MCH policy and planning efforts. A description of these relationships follows.

/2010/ OBO, formerly FHB, is now the Office of Maternal and Child Health. It is now located in DCH along with other DPH programs.//2010//

DIVISION OF PUBLIC HEALTH (DPH) is responsible for preventing and controlling disease and injury and promoting healthy lifestyles. The DPH state office, 18 health districts and 159 county health departments administer services that promote the health and well being of the whole community. County health departments also offer direct care to low-income individuals and people from underserved populations, or work with private medical providers to assure that those groups receive the care they need. /2009/ DPH's reorganization is described in Section B. Agency Capacity.//2009// ***/2010/ DPH's move to the Department of Community Health effective July 1, 2009 is described in Section B. Agency Capacity.//2010//***

DPH regularly collects, analyzes and shares information about health conditions, risks and resources in communities to public health to develop policies with appropriate priorities and goals. Vital Records births, deaths, marriages, and abortions records are utilized to produce vital statistics on the most common causes of death, as well as information about issues such as fertility and teen pregnancy. This information, together with hospital discharge data and other information, helps local health district staff design plans to improve the health of communities. The Office of Epidemiology oversees special surveys used by public and private groups to encourage behavior change and guide health policy. The Behavioral Risk Factor Surveillance System surveys Georgians yearly to determine the need for education about issues such as tobacco and alcohol use, seatbelt use, and exercise. The Pregnancy Risk Assessment Monitoring System (PRAMS) collects information from women about prenatal care and their health-related behavior before and during pregnancy and after delivery.

The MCH Epidemiology Unit generates information about MCH problems in Georgia that is used to design control and prevention measures, evaluate the effectiveness of public health interventions, and improve services to populations at greatest risk. Major surveillance project areas include the Pregnancy Risk Assessment Monitoring System (PRAMS), maternal mortality, pregnancy nutrition surveillance, pediatric nutrition surveillance, birth defects, newborn hearing screening, and perinatal surveillance. Program evaluation and assessment project areas include WIC, Medicaid, Babies Born Healthy, and data linkage. The Childhood Lead Poisoning Prevention Program distributes information to inform the public about lead poisoning, collects data to define the nature and extent of the state's problem, and collaborates with other agencies to solve Georgia's lead poisoning problem. All 18 public health districts test children for lead poisoning. Environmental health specialists investigate for lead hazards when a child's blood is found to have a high level of lead, and help property owners develop a plan for eliminating the problem.

The Tuberculosis (TB) Control Program works with local health agencies and with private providers to oversee active cases and increase directly observed therapy. /2009/ The Tuberculosis Unit is now housed in the Office of Essential Preventive Clinical Services' Communicable Diseases Section.//2009// TB is housed in Infectious Disease and Immunization.//2010//

The Sexually Transmitted Disease and HIV Programs offer testing, counseling, education, treatment and partner notification. A wide variety of PH activities help to prevent the spread of HIV/AIDS, including counseling and testing, voluntary partner notification, and case management. /2009/ The STD and HIV programs are now located in the Office of Essential Preventive Clinical Services, in the Communicable Disease Section, along with the Tuberculosis Unit.//2009// /2010/ STD is house in Infectious Disease and Immunization.//2010//

DPH provides funds for 21 rape crisis centers throughout Georgia that offer services to victims of sexual abuse including a 24-hour crisis line, crisis counseling, assistance to victims undergoing a forensic medical exam, assistance for victims and their families throughout criminal proceedings, long-term counseling and support groups. The centers also provide prevention education to parents, civic organizations, and middle school, high school and college students. A manual has been developed and training provided to law enforcement, medical, district attorney, and victim services personnel. /2009/ The State Rape Prevention Consultant is now housed in the Office of Health Behaviors Child and Adolescent Wellness Section.//2009//

The Women, Infant and Children (WIC) Nutrition Program provides special supplemental foods, nutritional counseling and breastfeeding support and education to low income women and their children up to age five. Georgia's WIC program is the 7th largest in the nation. WIC benefits are available to eligible pregnant or postpartum women, infants, and children up to the age of five. Eligible participants must have an income at or below 185% of U.S. Poverty Income guidelines;

be a state resident; and be at nutritional or medical risk, as determined by a health professional. On average, the Georgia WIC Program provides benefits to about 260,000 participants each month, with children the largest category of WIC participant types. In FFY 2004, 120,993 children, 70,239 infants, and 24,466 prenatals received monthly benefits through the Georgia WIC Program. WIC services are provided in Georgia through the state's 18 health districts and two contract agencies. Services are provided at over 267 health clinics, including 19 hospitals, 8 DFCS offices and via-in home certifications. Over 1,800 authorized food retailers participate in the WIC food delivery system. /2009/ Under the DPH reorganization, WIC is located in the OBO's Family/Community Support Services Unit.//2009//

The Immunization Program offers guidance and technical assistance on immunization issues to county health departments and private providers; provides access to vaccines to health departments, community health centers, homeless programs, and private providers and through the Vaccines for Children (VFC) program; and assures immunization coverage including vaccine preventable communicable disease outbreaks. Georgia law requires all children entering school or daycare to show proof of immunization. Beginning with the 2000-2001 school year, Georgia students entering 6th grade must show proof of immunity against varicella or chickenpox in addition to providing proof of protection against measles. To overcome barriers to vaccination, Georgia's public health departments remind parents when their children's vaccinations are due; offer extended clinic hours; give vaccinations on a walk-in basis; and distribute educational materials on immunizations. The VFC Program (VFC) provides free vaccines to private and public providers for children birth through 18 years of age who are Medicaid/CHIP-enrolled, American Indian/Alaskan Natives, and children whose vaccinations are not covered by insurance. Other projects include the Universal Hepatitis B Vaccination Program for infants, children and youth up to age 19; Perinatal Hepatitis B Prevention Program for pregnant women and babies born to infected mothers; and Vaccine Preventable Disease Surveillance and Vaccine Adverse Event Reporting Systems. /2009/ Immunization is housed in the DPH Office of Essential Preventive Clinical Services.//2009// **/2010/ The Office of Essential Preventive Clinical Services has become the Office of Immunization and Infectious Diseases.//2010//**

The Injury Prevention Program works with local health departments and other community coalitions to promote the correct use of car safety seats and bicycle helmets. Over 5,000 child safety seats and training on their use are provided each year to low-income families. The program works with fire departments to install smoke detectors in high-risk homes and homes with small children and older persons. FHB collaborates with Injury Prevention in press releases and State Suicide Prevention Plan. /2009/ The Injury Prevention Unit is now part of the Office of Protection and Safety and includes the Residential Fire Prevention Program, Core Injury Program, Intentional Injury, Child Occupant Safety Project, and Elderly Driving Assessment grants.//2009// **/2010/ MCH staff continue to collaborate with Injury Prevention, including care safety seat and bicycle helmet activities Injury Prevention is now housed in the Office of Emergency Preparedness .//2010//**

The Chronic Disease Prevention and Health Promotion Branch assists Georgians in achieving their highest level of health through the promotion of healthy lifestyles and the prevention of debilitating conditions. The goal of the Branch is to prevent disability and premature death by preventing or delaying development of chronic diseases and their complications. Surveillance activities and projects include arthritis, asthma, the Behavioral Risk Factor Surveillance System, cardiovascular health, diabetes, the Georgia Comprehensive Cancer Registry, Georgia Student Health Survey, injury, leading causes of death, overweight and obesity, physical activity, tobacco use, and surveillance of policies and environments affecting chronic diseases. /The Chronic Disease Prevention and Health Promotion Branch is now the Office of Health Promotion and Disease Prevention.//2010//

The Georgia Public Health Laboratory provides screening, diagnostic, and reference laboratory services to citizens of the state through county health departments, public health clinics, physicians, hospitals, and state agencies. The laboratory provides

laboratory testing for STDs, TB, and HIV. Its responsibilities also include newborn metabolic and sickle cell screening. /2009/ Under the DPH reorganization, the Laboratory is under the Office of Protection and Safety.//2009// The Georgia Public Health Laboratory is now under the office of Epidemiology and Laboratory.//2010//

DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND ADDICTIVE DISEASES (MHDDAD) provides treatment and support services to people with mental illness and addictive diseases, and support to people with mental retardation and related development disabilities. MHDDAD has five regions. Each region has a regional office, which is an extension of the MHDDAD state office to the local area. The regional office oversees the network of state-supported MHDDAD community and hospital services in the region. DPH works with MHDDAD around a number of state and local level concerns that relate to the MCH population such as youth risk prevention and tobacco use prevention. An ongoing dialogue, along with an array of activities, also exists addressing developmental disabilities and mental health concerns. A Mental Health representative serves on the BCW interagency coordinating council. DPH and FHB are collaborating with MHDDAD in a suicide prevention and child mental health group. FHB staff collaborate with MHDDAD in focused effort to enhance child and adolescent services in Chatham County **/2010/ Effective July 1, 2009, the Division became a new department, the Department of Behavioral Health and Developmental Disabilities (DBHDD). See Section B. Agency Capacity for additional information. MCH and DBHDD staff continue to work together collaboratively. For example, MCH staff serve on DBHDD's KidsNet and DBHDD and KidsNet staff participate in MCH's Early Child Comprehensive Systems Initiative (ECCS) initiative.//2010//**

DIVISION OF FAMILY AND CHILDREN SERVICES (DFCS) is responsible for: 1) protective services for children and adults, 3) Medicaid eligibility determinations, 3) subsidized child care, 4) troubled children placement, 5) Temporary Assistance for Needy Families (TANF) and food stamp, 6) job training and job search assistance for welfare applicants and recipients, and 7) child support enforcement and collection, and social services. In a structure that parallels local public health agencies, county DFCS offices administer these services. Direct linkages and work groups are maintained between DPH and DFCS to assure Medicaid eligibility, streamlining and removal of access barriers. Extensive referral linkages exist between DPH and DFCS at the county level, particularly through Children 1st. The Division has established the Office of Child Protection to create an environment that supports staff in their job functions, expand collaborations with partners to enhance support, reduce staff turnover, and create technical and program supports for caseworkers in the field. **/2010/ Effective July 1, 2009, DHR was reorganized. DFCS is now located in the Department of Human Services.//2010//**

The DFCS Family Violence Program administers funds for Georgia's family violence programs. Staff also provide technical assistance and training, information to family violence staff and boards, and certification for shelters based on standards set by DHR's Advisory committee on Domestic Violence. Georgia has 43 certified family violence programs, operated by private, nonprofit organizations that provide 24-hour crisis lines, legal and service advocacy, children's programs, parenting support and education, emotional support, and community education. Thirty-eight of these programs also offer emergency safe shelters. A statewide toll-free crisis line (1-800-33-HAVEN) automatically connects callers to the nearest family violence agency.

The Fatherhood Program, created by DFCS' Child Support Enforcement office, helps parents who are unable to pay their child support. The program offers job placement, vocational training, counseling and a chance to earn a GED and the opportunity to play a supportive role in the lives of their children. It is available to any non-custodial parent paying child support through CASE who is unemployed or employed but earns less than \$20,000 per year; has children receiving TANF; and/or who lacks a high school diploma or GED.

OFFICE OF REGULATORY SERVICES (ORS) - inspects, monitors, licenses, registers and certifies a variety of health care facilities including hospitals, laboratories, home health agencies,

long-term care facilities, residential care facilities, and private adoption agencies. ORS also certifies various health care facilities to receive Medicaid and Medicare funds through contracts and agreements with the Georgia DCH and Centers for Medicare and Medicaid and Drug Administration of the U.S. Department of Health and Human Services. ***/2010/ Effective July 1, 2009, DHR was reorganized. ORS is now located in the Department of Community Health, Division of Healthcare Facility and Regulation./2010/***

SOCIAL SECURITY ADMINISTRATION, REHABILITATION, AND DISABILITY UNIT - contracts with the Department of Labor Office of Rehabilitation Services for state disability adjudication services and determines the eligibility of children birth to age 21 for SSI.

DEPARTMENT OF COMMUNITY HEALTH (DCH) - includes Medical Assistance (Medicaid), State Health Planning Agency, and State Employees Health Benefit Plan. The State Health Planning Agency conducts overall state health planning and makes certificate of need determinations. Medicaid maintains a renewable, annual contract for administrative and support services with the DHR. Under this agreement, DHR agrees to provide support services and Medicaid agrees to pay the appropriate Federal share of the administrative cost of these services. Services provided by DPH under the contract include: newborn metabolic screening, Health Check outreach, screening and follow-up; Children 1st; the Powerline; Regional Maternal and Infant Intensive Care program; Universal Newborn Hearing and Screening (UNHSI); MCH epidemiology, Presumptive Eligibility; and WIC referrals. DPH and Medicaid work together around a number of specific initiatives arising from these contracted activities. DPH and the FHB also work with DCH's Office of Women's Health which serves as a clearinghouse of information on non-reproductive health issues as well as a link to other groups and institutions in the state involved with women's well being. Georgia is one of eight states to establish a women's health office. DCH's Office of Minority Health works to eliminate the disparity in health status between minority and non-minority populations. DCH and FHB collaborative efforts include activities related to developmental screening, women's and children's services, children with special needs, and men's health. ***/2007/ With the Department of Community Health's June 1, 2006 implementation of managed care (Georgia Healthy Families) for many of the state's Medicaid recipients and CHIP participants, DCH and DHR are working collaboratively to delineate the role of Public Health with Care Management Organizations (CMOs). There are three CMO providers and all may have different agreements for services traditionally provided by the state's 159 county health departments. State and local Public Health staff have collaborated with DCH in presenting logic models and program justification to the CMOs. County health departments are working with the CMOs to establish contracts./2007/ /2010/ Georgia Healthy Families, the state's Medicaid enrollment broker, is now known as Georgia Families. This statewide program, designed to deliver health care services to members of Medicaid and PeachCare for Kids, is a partnership between DCH and the three Care Management Organizations (CMOs). By providing a choice of health plans, Georgia Families allows members to select a health care plan that fits their needs.***

Effective July 1, 2009, DPH transitioned to DCH./2010/

DEPARTMENT OF CORRECTIONS AND DEPARTMENT OF JUVENILE JUSTICE - interact with DPH around communicable disease issues, particularly STD, AIDS, nutrition education and tuberculosis. The Departments of Juvenile Justice (DJJ), Corrections, Pardons and Parole, and the FHB are working collaboratively to strengthen relationships and create a continuum of care for youth leaving the state's youth detention centers to address their need for community-based health and mental health services.

DEPARTMENT OF EARLY CARE AND LEARNING (DECAL) -- In May 2004, the Georgia General Assembly created Bright from the Start: Georgia Department of Early Care and Learning. This new state agency is responsible for overseeing child care and educational services for Georgia's children ages birth to five. Bright from the Start's responsibilities include: administering Georgia's Pre-K Program; licensing approximately 3,000 child care learning centers and group

daycare homes; registering more than 5,000 family day care homes; administering two federal nutrition programs (the Child and Adult Care Food Program and the Summer Food Service Program); housing the Head Start State Collaboration Office; implementing the Standards of Care Program to enhance the quality of child care provided to infants, toddlers, and three year olds; funding/partnering with the child care resource and referral agencies; collaborating with Smart Start Georgia and the Department of Education's Even Start Family Literacy Program to blend federal, state, and private monies to enhance early care and education; and distributing federal child care development funds. Even Start was transferred from the Department of Education to DECAL in June 2005. DECAL and DPH have a MOA for enhanced services to support early childhood health and development for children and youth. DECAL and DPH are working in collaboration to develop a comprehensive early childhood care system (ECCS).

DEPARTMENT OF EDUCATION (DOE) - has a memorandum of agreement with the DCH and DHR commissioners that endorses and encourages joint health and human services and education planning and programming targeting reductions in teen pregnancy, substance abuse, school failure and delinquency. In many parts of the state, strong relationships have been developed between Public Health and the schools. DOE is responsible for the Youth Risk Behavior Survey and the CDC Youth Tobacco Survey that are conducted in collaboration with DPH Epi Section. Data from these surveys are important to MCH planning and health outcome efforts.

CHILDREN'S TRUST FUND - disperses funds for grants to public and private child abuse and neglect prevention programs and funds services connected with child abuse and neglect prevention. The agency is part of the State Agency Prevention Work Group.

/2007/ FAMILY CONNECTION PARTNERSHIP - The Family Connection Partnership is a public/private partnership created by the State of Georgia and funders in the private sector to help communities address the serious challenges facing Georgia's children and families. The Partnership also serves as a resource to statewide agencies and organizations that work to improve the conditions of children and families. As a nonprofit intermediary organization, the Partnership works closely with community, state, and national partners to provide training and technical assistance to Family Connection county collaboratives; enhances public awareness, understanding, communication, and commitment to improve results for children and families; and uses research and evaluation to promote effective practices and programs.//2007// /2008/ Family Connection Partnership 2006 KIDS COUNT community forums and PeachCare for All Kids Lunch-N Learns were held in eight sites across Georgia to help local communities learn about child well-being in the state, understand policy and legislation that impacts families, and provide an overview of Georgia's budget and spending priorities. //2008// /2009/ Family Connection is conducting a study, funded in part by the Georgia Early Childhood Comprehensive System Initiative (OBO is ECCS grantee), on current family support practice and training by state and state-level agencies and organizations. Study methodology includes one-on-one interviews with leadership, written surveys of mid-level managers and frontline workers, focus groups with mid-level managers and with family members. The role of families in governance, planning, and evaluation is also included in the study.//2009// **/2010/ The family support study has been completed. An analysis and reporting of data is underway. Study findings have been shared with the ECCS Collaborative Partners Committee.//2010//**

RELEVANT COUNCILS - The Governor's Council on Maternal and Infant Health is legislatively mandated to "serve in an advisory capacity to the Governor, DHR and any other state agencies in all matters relating to maternal and infant health." The Council also makes recommendations on the improvement of Georgia's maternal and infant health care system. Composed of 17 obstetricians, pediatricians, family physicians, consumers, and other providers, the Council monitors pertinent legislation affecting women and infants, and publishes information related to maternal and infant health. The Newborn Metabolic Screening Advisory Committee is a subcommittee of the Council on Maternal and Infant Health. The Governor's Council on Developmental Disabilities (DD Council) serves as an advisory body and provides broad policy

advice and consultation to state agencies. The Interagency Coordinating Council (ICC) for Early Intervention, mandated under Part C of IDEA, is appointed by the Governor to advise and assist DHR in planning, coordinating and implementing a statewide system of early intervention services for children with or at risk for developmental delays. The Governor's Children and Youth Coordinating Council was created to provide effective coordination and communication between providers of services for adolescents and children. FHB's AHYD Office works closely with the Council to support the implementation of Georgia's federal abstinence education grant, administered by the Council. /2009/ Ten state-level partner agencies and organizations (Parent Leadership Coalition) initiated navigator teams in ten counties to assist families of children with disabilities. Through ECCS, the focus has been broadened to assist all parents in their respective communities to access early childhood services. There are now 42 teams serving 47 counties. Resource training involving ECCS partners and stakeholders has been held for county navigator teams. Through the help of Parent Leadership Coalition (PLC) members, initial contacts have been identified in targeted counties. The PLC has expanded its steering committee membership to include ECCS co-chair of the Access to Medical/Dental Home Work Group. A contract has been negotiated with Dr. Susan Yuan from Vermont's University Center of Excellence Program to conduct a formative evaluation of the 10 original navigator teams, funded in part by ECCS. Evaluation activities, which began in April 2008, include a review of service records, meeting minutes, conducting family/patient satisfaction surveys, navigator team member assessments, and collecting and analyzing indicator data.//2009// **/2010/ Evaluation activities have been completed, Analysis and reporting of study data is underway./2010//**

FEDERALLY QUALIFIED HEALTH CENTERS - 17 Section 330 community health centers (CHC) provide comprehensive preventive and primary health services. A number of CHCs provide perinatal case management services and newborn follow-up.

TERTIARY CARE FACILITIES -- Relationships have been established throughout the state with tertiary care facilities with technical resources that have enhanced Georgia's capacity to offer services to women of childbearing age, infants, children and adolescents. The state has two Level II pediatric trauma centers, four children's hospitals, and two burn units. Regional perinatal services are provided statewide through six designated tertiary care hospitals located in Atlanta, Macon, Augusta, Columbus, Albany and Savannah. High-risk perinatal services provided include transportation, prenatal care, delivery, post-partum care, and newborn care. A regional perinatal planning process facilitates planning in each of the six perinatal regions, bringing together in each region representatives from hospitals, district public health, and community organizations.

TECHNICAL RESOURCES - DPH collaborates with the state's Distance Learning and Telemedicine Program (GSAMS) network to bring specialty health care to areas with limited access. BCW also utilizes telehealth technology. All four of the State's medical schools have faculty that participate in the CMS program. The Centers for Disease Control and Prevention (CDC) is a valuable resource in providing technical assistance and resources to the Branch. The Rollins School of Public Health at Emory University works with DPH in many areas: internships for students; program evaluation and outcome evaluation; and technical assistance and consultation. The Morehouse School of Medicine works closely with the Branch on issues impacting women. Several other universities (Georgia State, University of Georgia, and Clayton State) also work with DPH, providing technical assistance, research, and training.

PROFESSIONAL ORGANIZATIONS -- DPH programs work on an ongoing basis with the Medical Association of Georgia, Georgia State Medical Association, Georgia Chapter of the American Academy of Pediatrics, Georgia Academy of Family Physicians, Georgia Chapter of the College of Obstetrics and Gynecology, and other professional groups to promote increased private sector involvement in serving women and children in need.

ADVOCACY ORGANIZATIONS -- DPH works collaboratively with major MCH advocacy organizations, such as the March of Dimes, Healthy Mothers/Healthy Babies, Save the Children, SAFE KIDS of Georgia, Voices for Georgia's Children, and the SIDS Alliance.

F. Health Systems Capacity Indicators

Introduction

Data on the health systems capacity indicators listed below is reported on forms 17,18, and 19.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	36.4	32.3	32.3	25.8	22.0
Numerator	2473	2236	2236	1810	1625
Denominator	679064	692726	692726	702134	737422
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2006

2006 Data is not yet available. Will be added to the FY 2009 MCHBG

Narrative:

Georgia Addressing Asthma from a State Perspective (GAASP), formed in 2001 and led by DPH, includes representation from more than 30 organizations, including academic institutions, advocacy groups, professional organizations, private and public health care centers, and a private foundation. GAASP examined the prevalence, mortality, and morbidity of asthma in developing its Burden of Asthma in Georgia 2003 Report. The following year, The Strategic Plan for Addressing Asthma in Georgia 2004 was produced. This plan includes a description of the burden of asthma in Georgia, an assessment of state resources and gaps, strategies to decrease the asthma burden, and methods to identify and promote key messages to the general public and health care providers.

In collaboration with CDC, the Environmental Protection Agency, American Lung Association of Georgia (ALA), and other community partners, World Asthma Day activities have been conducted to raise awareness about asthma and its burden. The state asthma program partners with ALA to provide an Asthma 101 program to parents, educators, and school nurses. The Open Airways for Schools curriculum is provided to middle schools.

The state asthma program has awarded grant-in-aid funds ranging from \$5,000 to \$10,000 to eight Georgia public health districts/coalitions to conduct interventions and implement asthma prevention strategies to serve communities that are disproportionately affected by asthma. Another of the program's partners, the Medical Association of Georgia, is offering training to health care providers to improve their knowledge, attitudes, and practices in asthma management.

/2007/ 2006 activities have included asthma case management; collaborating with CMS through the Title V Block Grant to provide care coordination; participating in World Asthma Day events to raise awareness about asthma and its burden; and collaborating with the American Lung Association of Georgia to provide Asthma 101 programs to parents, educators, and school

nurses. The asthma case management train-the-trainer program provided training statewide for district staff. //2007//

/2008/ The Georgia Asthma Advisory Council (GAAC) is revising the asthma work plan. Mini-grants of \$10,000-15,000 are available to support achievement of work plan goals.//2008//

/2009/ OHB and GAASP continue to collaborate on surveillance and data collection efforts focused on decreasing the rate of children under age five hospitalized for asthma. Surveillance data was used to create a comprehensive document describing the burden of asthma in Georgia and to identify populations who are disproportionately affected by asthma or are at risk for poorly controlled asthma. The "2007 Georgia Asthma Surveillance Report," published in September 2007, presents data on asthma prevalence and risk factors, work-related asthma prevalence, healthcare utilization, deaths, asthma severity, and management practices for all age groups. This report is the third, and most comprehensive report available, to describe the burden of asthma in Georgia and to guide public health programs, policymakers, and healthcare providers in planning, implementation, and evaluation of interventions and programs to reduce the asthma burden in the state.//2009//

/2010/ According to the 2007 Georgia Asthma Surveillance Report, asthma is a major public health problem in Georgia, affecting people regardless of sex, age, or race/ethnicity. An estimated 230,000 (10%) children ages birth to 10, approximately 56,000 (15%) middle school and 70,000 (16%) high school students, and about 480,000 (7%) adults in Georgia have asthma. There were approximately 49,000 emergency room (ER) visits in 2006 in Georgia with asthma as the primary diagnosis. The overall rate of ER visits due to asthma was 516 per 100,000 population. ER charges related to asthma totaled over \$50 million. According the Georgia Asthma Surveillance Report 2007, blacks were three times more likely to visit the ER with asthma than whites (947 vs. 273 per 100,000 populations). Females were 1.2 times more likely to visit the ER than males (516 vs. 417 per 100,000). Black females had the highest ER visit rate (955 per 100,000) among the four major race-sex groups in Georgia. Black females were three times more likely to visit the ER than white females. Black males were four times more likely to visit the ER than White males. Children aged birth to 4 have the highest ER rate, 1,328 per 100,000 population. A possible contributing factor is that asthma is often misdiagnosed and confused with other upper respiratory diseases in this age group.

Thirty of Georgia's 159 counties had significantly higher ER visits than the state rate (510 ER visits per 100,000 per year) in 2005. Counties with high rates are located throughout the state, but high rates are more common in the southwest corner of the state.

Asthma hospitalization rates in Georgia are four times higher among children ages 0-4 and two times higher among adults ages 65 and older compared to other age groups. During 2006, there were more than 10,000 hospitalizations for asthma in Georgia; hospital charges related to asthma totaled more than \$124 million in 2006.//2010//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	70.9	71.7	77.2	67.7	58.5
Numerator	143120	154202	150013	41927	34339
Denominator	201869	214929	194261	61933	58736
Check this box if you cannot report the numerator					

because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008

This data excludes all CMO data. CMO plans were implemented in June 2006 and therefore, counts maybe be lower than expected from this period forward.

Notes - 2007

This data excludes all CMO data. CMO plans were implemented in June 2006 and therefore, counts maybe be lower than expected from this period forward.

Narrative:

Eligible Medicaid children are assigned to a medical provider through the state's Medicaid program shortly after birth. All Medicaid enrolled children who are at high risk for medical and other health or developmental conditions are referred to Children 1st and/or High Risk Infant Follow-up (HRIFU) to ensure they receive appropriate health care follow-up. HRIFU provides home or clinic visits by Public Health nurses to families with infants up to one year of age, who have a medical condition, especially those with low and very low birth weight. HRIFU ensures that the families are making visits to the primary care provider for recommended periodic exams. The percent of infants who are enrolled in HRIFU and are on Medicaid ranges from approximately 60% to over 90%, depending on the health district of residence of the family. The FHB ICH well child team conducts EPSDT reviews of children enrolled in Medicaid, focusing on infants who received well child screens by private medical practitioners. Chart reviews in the majority of public health districts reveal infants have had well child (EPSDT) screens performed.

/2007/ Beginning June 1, 2006, all Georgia Medicaid or PeachCare enrolled children will be matched with one of three Georgia Healthy Families Care Management Organizations (CMO) (Amerigroup Community Care, Peach State Health Plan, and WellCare). Each enrolled member will be assigned a primary care provider (PCP). At the request of CMOs, Public Health's HRIFU will make visits to CMO enrolled members. HRIFU will continue to serve non-CMO infants, such as those without insurance, in foster care, or on SSI.//2007//

/2008/ Children 1st continues to be a key public health services access point for families. Children ages 0 to 5 at risk of poor health and development are identified and referred to other services, such as CSN and EPSDT.//2008//

/2009/ Children 1st, within the new Birth to Five System, remains Georgia's single point of entry for families of young children birth to five.//2009//

/2010/ DCH data shows that 64% of infants under the age of one enrolled in Medicaid received at least one EPSDT screen. Georgia Healthy Families is now known as Georgia Families. HRIFU was cut in the SFY 2009 budget due to a significant decrease in state revenues. However, services continue in some health districts. //2010//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	59.6	63.2	60.5	57.5	50.6
Numerator	1618	1707	1711	1069	533
Denominator	2713	2702	2828	1859	1054
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008

This data excludes all CMO data. CMO plans were implemented in June 2006 and therefore, counts maybe be lower than expected from this period forward.

Notes - 2007

This data excludes all CMO data. CMO plans were implemented in June 2006 and therefore, counts maybe be lower than expected from this period forward.

Narrative:

Eligible PeachCare for Kids children are assigned to a medical health care provider through the Georgia Better Health Care program shortly after birth. All PeachCare for Kids enrolled children who are at high risk for medical and developmental conditions are referred to Children 1st and/or High Risk Infant Follow-up to ensure they receive appropriate health care follow-up. The FHB ICH well child team conducts EPSDT reviews of children enrolled in PeachCare for Kids, focusing on infants who received well child screens by private medical practitioners. Chart reviews in the majority of public health districts reveal infants who had well child (EPSDT) screened performed.

/2007/ Beginning June 1, 2006, all Georgia Medicaid or PeachCare enrolled children will be matched with one of three Georgia Healthy Families Care Management Organizations (CMO) (Amerigroup Community Care, Peach State Health Plan, and WellCare). Each enrolled member will be assigned a preferred care provider (PCP). At the request of CMOs, the Public Health's HRIFU will make visits to CMO enrolled members. HRIFU will continue to serve non-CMO infants, such as those without insurance, in foster care, or on SSI.//2007//

/2008/ Because of federal funding shortfalls, PeachCare enrollment was closed March 2007. At the time of the freeze, more than 300,000 children had PeachCare coverage. Approximately 5,000 children a month have been dropped because of late premium payments. DCH has issued a notice of its intention to reopen PeachCare enrollment beginning July 12. Approximately 10,000 to 15,000 enrollees will be accepted with enrollment capped at 295,000. PeachCare coverage will be reassessed when Congress reauthorizes and funds SCHIP. //2008//

/2009/ Congress reauthorized SCHIP in September 2007. Georgia received \$325 million. The PeachCare enrollment cap remains in effect. //2009//

/2010/ DCH data indicates that 63% of infants under the age of one enrolled in PeachCare for Kids (SCHIP) received at least one EPSDT screen.//2010//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	73.4	68.9	68.9	66.0	66.0
Numerator	96928	97082	97082	97943	97943
Denominator	132107	140903	140903	148403	148403
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008

Due to a change in data collection the data for this year has been determined unreliable. Steps are being taken to resolve this issue and the data will be updated in the 2011 Block Grant.

Notes - 2006

2006 data is not yet available and will be provided in the FY 2009 MCHBG.

Narrative:

/2007/ The FHB is continuing outreach efforts, through the statewide Perinatal Case Management (PCM) program, to increase access to prenatal care and referrals to prenatal providers during the first trimester of pregnancy. Referrals for uninsured and underinsured pregnant women also are encouraged through PowerLine (Georgia's Title V toll-free number) referrals to providers that offer low-cost or no-cost prenatal care. The Perinatal Health Partners Program (funded by FHB and Medicaid) in the Waycross Health District provides intensive medical and social case management services to high-risk OB clients to ensure they receive prenatal care and deliver at a facility with an appropriate level of care. The Public Health nurses and outreach workers who provide these services also follow-up the infants of their high-risk OB clients in the HIRFU program.

The Babies Born Healthy (BBH) Program helps low income, uninsured and underinsured pregnant women receive comprehensive, quality, prenatal services as early as possible in their pregnancy. Services are provided through partnerships with local providers, such as physicians, nurses, nurse midwives, nurse practitioners, nutritionists, social workers, health educators, and are available for women who are not eligible for Medicaid or other health care coverage. BBH pays for prenatal care, hospital delivery, limited newborn care for eligible women, and case management services in their health districts. Services are provided through partnerships with local providers. Low income (family income at or below 250% of federal poverty income guidelines), non-Medicaid eligible pregnant women and their newborns are eligible for BBH services. In FY 2005, BBH paid for 3,933 uninsured and underinsured women to receive prenatal care.//2007//

/2008/ The BBH program continues to serve a large population of uninsured/underinsured participants who are ineligible for Medicaid. In 2006, 3,959 uninsured/underinsured women received prenatal care.//2008//

/2009/ The Perinatal Health Partners program is now fully funded by the Office of Birth Outcomes. In FY 2007, the program was expanded into two new counties in the Waycross health district.

The demand for the Babies Born Healthy Program continues to be greater than available funds. In 2007, the program served 3,568 clients.//2009//

/2010/ DPH, in collaboration with DCH and CMOs, has developed and implemented a rapid process improvement pilot project in DeKalb County to improve the enrollment process of pregnant women into first trimester care. If successful, the project will be implemented statewide. The Babies Born Healthy program remains flat funded with program demands remaining greater each year than available funding. In FY 2008, the program served 3,542 clients. The Perinatal Health Partners program received additional grant funding which facilitated expansion into four new counties.//2010//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	81.8	81.1	80.8	62.4	56.4
Numerator	836413	875228	846040	342870	321935
Denominator	1022414	1078849	1046926	549714	570877
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008

This data excludes all CMO data. CMO plans were implemented in June 2006 and therefore, counts maybe be lower than expected from this period forward.

Notes - 2007

This data excludes all CMO data. CMO plans were implemented in June 2006 and therefore, counts maybe be lower than expected from this period forward.

Narrative:

/2007 With the move to Medicaid managed care, FHB programs are working with DCH and district staff to ensure coverage for needed MCH services. Logic models have been developed and referral processes negotiated for major Public Health programs. FHB's children's and teen programs aggressively link eligible children to Medicaid and implement activities to make sure parents of potentially Medicaid eligible children know how to access Medicaid services. ***//2007//***

/2008/ In June 2006, the Department of Community Health (DCH) implemented managed care for Medicaid recipients and SCHIP participants. DCH and DHR have been working to delineate the role of Public Health with Care Management Organizations (CMOs). Each of the state's three CMO providers have a different agreement for services traditionally provided by the state's 159 county health departments. FHB is working to educate families new to Medicaid managed care process to assist them in navigating the services and regulations of a Care Management Organization (CMO). With implementation of Georgia's Medicaid managed care system and the family's choice of a CMO, the PCP member of the selected CMO is the child's "medical

home."//2008//

/2009/ Approximately 63% of CMS enrolled children have Medicaid.//2009//

/2010/ In FFY 2008, Georgia had 942,817 children ages 1-21 enrolled in Medicaid. Of these, 78% (736,052) received a service paid by Medicaid. Data from Medicaid's Care Management Organizations (CMOs) may not be complete, so this may represent an undercount of children served.//2010//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	48.3	51.4	47.3	23.4	20.9
Numerator	152693	173685	112068	27076	25196
Denominator	316303	337979	236724	115852	120726
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008

This data excludes all CMO data. CMO plans were implemented in June 2006 and therefore, counts maybe be lower than expected from this period forward.

Notes - 2007

This data excludes all CMO data. CMO plans were implemented in June 2006 and therefore, counts maybe be lower than expected from this period forward.

Narrative:

The FHB Oral Health Section (OHS) and the district Georgia Oral Health Prevention Program (OHP) provide dental services to underserved school children by targeting schools with high numbers of free and reduced lunch program participants. Services at targeted schools include screenings or examinations, sealants, fluoride applications, preventive educational services, and fluoride mouthrinse programs when appropriate. OHP maintains a list of referral sources that accept Medicaid and PeachCare reimbursements, including public health facilities. OHS provides technical assistance and consultation to health district dental directors on the Medicaid/PeachCare Care Managed Organization system implementation. Evaluation of Medicaid/PeachCare claims data provides information on access to care for eligible participants.

The HRSA funded Georgia Access to Dental Services grant (GADS I, FY 2002-2006) has been utilized to increase access through community coalitions. Statewide replication of best practices will be initiated through sharing at a statewide Oral Health Summit meeting to be held 2nd quarter

FY 2006. Through continuation of the States Oral Health Collaborative Systems Grant (GADS III, 2004-07), infrastructure has been built and strengthened, and access to care has been increased through community collaborations and conducting measurements of oral health status. The Georgia 3rd Grade Oral Health Survey has been implemented to provide statewide assessment of the oral health status of elementary school children. The majority of the 3rd graders screened were between eight and nine years of age. Fifty-seven (57) percent of the children screened had experienced dental caries compared to the Healthy People 2010 objective of 42%; 27% had untreated caries (Healthy People objective 2010 of 21%), and 39% had dental sealants (Healthy People objective 2010 of 50%). Plans for a Head Start screening survey are being developed. OHS will also participate in a statewide Head Start symposium.

OHS collaborates with School Health programs to ensure appropriate screenings prior to school entry. Increasing the availability of dental services (fillings and minor oral surgeries) for children ages 6-9 is a continuing goal of the OHS. Mobile dental trailers are now equipped to provide these services at elementary school sites. The Section also conducts individual district technical assistance, monitoring, and evaluation site visits to address grant project needs and district data concerns.

//2007/ Statewide best practices replication was initiated at a statewide April 2006 Oral Health Summit meeting. OHS also participated in a statewide Head Start Forum 2006. Planning for a Head Start screening survey is in process. Two additional mobile dental trailers have been added (total of 11 trailers and two vans) to help provide screening services at elementary school sites. //2007// /2008/ The Georgia Head Start Oral Health Screening Survey, funded by the GADS III grant, was implemented in SFY2007. Preliminary data is available with final analysis to be completed by the Epi Branch. A final report is expected in summer 2007. Fluoride varnish programs targeting at risk children have been implemented. Another mobile dental unit was added in the Dalton area, bringing the total number of units to 12, plus two vans in Fulton County. Training materials are being developed through a contract with MCGSD to assist training of medical and dental professionals in the application of fluoride varnish, screening of young children, and to provide training to Head Start staff and parents in the oral care of young children. The 2007 Head Start Oral Health Forum provided follow-up information and a progress report on accomplishments on the oral health plan created during the 2006 forum. A September 2006 collaboration with MCGSD secured a workforce development grant to provide public health dental clinic internships in underserved communities to senior dental students. Annual Medicaid and SCHIP service access reports have been published and shared, including trend analyses 2000-2005. In SFY 2006, the statewide oral health prevention program provided 9,188 children with dental sealants and screened 61,660 children. Also, 8,302 children participated in fluoride mouth rinse programs, 79,203 children were provided with oral health education, and 46,506 children without access to a community dentist received dental treatment services.//2008// /2009/ More than 47,169 dental treatment visits were provided to children in FY 2007. First priority is given to children who need emergency dental services and who are eligible for the Free and Reduced Meal Program (185% Federal Poverty Level). Basic dental treatment services include exams, cleanings, dental sealants, fillings, minor oral surgeries, and extractions. In SFY 2007, 8,085 children received dental sealants and 12,737 received fluoride rinses.//2009//

//2010/ Oral Health is instituting a Monitoring and Surveillance Plan that includes the Georgia 3rd Grade and Head Start surveys as regularly occurring events on a three-year cycle, as well as inclusion of Oral Health questions in national surveys//2010//.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	7.6	7.1	6.9	6.5	6.1
Numerator	2054	2019	2056	1987	1942
Denominator	27170	28487	29741	30796	31950
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2006

The numerator is from the CMS program (Title V CSHCN) Jan-March 2006.

Narrative:

The FHB assists families of CSHCN in identifying and accessing insurance resources. Educational sessions have been provided to Health District Coordinators on Medicaid (i.e., Right from the Start Medicaid, Emergency Medicaid, Deeming Waiver and Medically Needy Spend Down). The percent of SSI beneficiaries less than 16 years of age in the state who are enrolled is currently 10%. The range of SSI beneficiaries varies greatly by health district. FHB's CSN Program will continue to monitor this indicator using district quarterly reports.

/2007/ The percent of Georgia's SSI beneficiaries less than 16 years of age who are enrolled in the state CSHNC program is 27%. The range of SSI beneficiaries continues to vary greatly by health district.//2007//

/2008/ There are 2,014 children under 16 years of age who are receiving SSI and are enrolled in CMS. This represents 24% of the total CMS enrollment. //2008//

/2009/ 23% (1,930) of enrolled CMS clients (8,491) under the age of 16 years old are Georgia SSI beneficiaries. //2009//

/2010/ The percent of Georgia's SSI beneficiaries less than 16 years of age who are enrolled in the state CSHNC program is 27%. The range of SSI beneficiaries continues to vary greatly by health district. There are 2,347 children under the age of 16 who are receiving SSI and are enrolled in CMS. This represents 24% of the total CMS enrollment. 20% (1,763) of enrolled CMS clients (8,477) under the age of 16 years old are Georgia SSI beneficiaries.//2010//

Health Systems Capacity Indicator 05A: Percent of low birth weight (< 2,500 grams)

INDICATOR #05 Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2007	other	9.8	8.2	9.1

Notes - 2010

Due to the loss of a Medicaid contract, we no longer receive Medicaid delivery claims files and therefore cannot link Medicaid delivery claims with Birth certificates. 2004 is the most current linkage available.

Narrative:

/2007/ Georgia's Perinatal Regional System provides funding through the Department of Community Health to six designated regional tertiary hospitals to provide high-risk perinatal services, including transportation, prenatal care, delivery, post partum care, and newborn care. Tertiary hospitals also provide outreach and education to area providers to further a seamless community-based system in Georgia. Women who are at or below 250% of federal poverty level are eligible for funding of these services.

Perinatal Case Management (PCM), a Medicaid funded program, provides case management to high-risk Medicaid pregnant women. Services are provided in the public and private sector. Nurses and social workers conduct individual assessments and follow-up for eligible women throughout their pregnancies, as well as linking them to prenatal care, Children 1st, and other medical and social services. About 44,000 women received PCM in FY 2005. Pregnancy Related Services, also a Medicaid funded program, provides post partum home visits to pregnant women to reduce infant mortality. //2007//

/2008/ DHR and DCH continued to collaboratively fund the regional perinatal centers (RPC) to provide care for high risk perinatal women and infants. RPC Outreach Educators also continued to provide educational support to community hospitals, community providers, and local boards of health. In CY 2005, the RPCs provided care for 5,504 high-risk neonates and 13,183 high-risk maternal patients.

Public Health nurses continue to provide PCM and PRS services but on a limited basis due to the state's move to Medicaid managed care and the new role of Care Management Organizations (CMO). Newly diagnosed patients are provided with PCM information and local boards of health continue to complete the initial, comprehensive evaluation. This information is provided to the patient's CMO. Additional assessments are completed with CMO approval.//2008//

/2009/ DCH and DHR continue to collaboratively fund Georgia's regional perinatal centers for risk appropriate healthcare services for high-risk mothers and infants. In FY 2007, 5,725 high-risk babies and 12,597 high-risk mothers were eligible for the program. The State Legislature proposed an additional \$500,000 to improve transportation for high-risk neonates.//2009//

/2010/ Activities continue from previous years with no significant changes. Due to budgetary shortfalls, grant funding for the regional perinatal centers was reduced by \$200,000. The reduction was implemented in the administrative budget with minimal impact on patient benefits. The program lost \$500,000 for high-risk transport improvement.//2010//

Health Systems Capacity Indicator 05B: Infant deaths per 1,000 live births

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2007	other	9.6	7.4	7.9

Notes - 2010

Due to the loss of a Medicaid contract, we no longer receive Medicaid delivery claims files and therefore cannot link Medicaid delivery claims with Birth certificates. 2004 is the most current linkage available.

Narrative:

//2007/ MCH Epidemiology conducts analyses of infant deaths to identify groups at highest risk and to identify risk factors that may be potentially modifiable. Results from these analyses are being used to target intervention efforts in communities with the highest rates of infant death and to focus efforts on effective interventions.

Finding Opportunities through Collaboration, Understanding, and Science (FOCUS), a state and local public health partnership to address Georgia's infant mortality rates and poor birth outcomes, is initiating and facilitating community-oriented, data-driven, and system focused planning processes at the local level. Key data include an analysis of Perinatal Periods of Risk data and mapping of incidence of fetal and infant mortality in some of the counties with the state's highest rates and numbers of infant mortality. State and local staff have discussed data implications and intervention opportunities. Strategies to address local level issues will be developed during the next few months. "Talking Out Loud" sessions have also been held to discuss needs, concerns, and best practices. Discussion topics have included infant mortality, tobacco use prevention, and obesity. Counties with the highest rates of infant mortality have been identified and the information shared with state workgroup partners. This information will be disseminated through integrated site visits to the health district offices in which the counties with the highest infant mortality rates are located. Current FOCUS counties include Clayton, Chatham, and Lowndes, with potential future expansion. Work is under way on the development of strategies to reduce prenatal disparities and infant mortality and morbidity.//2007// //2008/ Some of the preconception health initiative activities to improve women's health and birth outcomes target FOCUS counties. Funding is being provided to the Georgia Academy of Family Physicians to educate and stimulate family physician practice changes through "quality circles," groups of volunteer physicians that meet at various times throughout the year to have discussions on a specific topic, lead by a "champion" physician. They also conduct chart audits to assess if practice changes have been made in response to identified discussion issues.//2008//

//2009/ Collaborative efforts continue with the Georgia Academy of Family Physicians to educate family physicians and implement change based on best practices through "quality circles" with other physicians.

Clayton County initiated "Partnership to Improve Birth Outcomes," a community-based effort with key stakeholders to improve birth outcomes. Richmond County, which has high infant mortality rates, implemented a fetal infant mortality review committee to help reduce infant mortality by identifying trends in fetal and infant deaths and using a coordinated community approach to develop strategies to improve birth outcomes. The OBO contracted with Emory University to develop a reproductive planning and preconception care tool that will facilitate the provision of appropriate family planning and evidence-based preconception care strategies as part of women's primary health care.//2009//

2010/ Activities continue from previous years with no significant changes. The State hopes to establish a Maternal Pregnancy Associated Mortality Review Committee.//2010//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	other	76.7	91.8	83.3

Notes - 2010

Due to the loss of a Medicaid contract, we no longer receive Medicaid delivery claims files and therefore cannot link Medicaid delivery claims with Birth certificates. 2004 is the most current linkage available.

Narrative:

/2007/ All FHB programs aggressively link patients with available fund sources they are eligible for to support the delivery of FHB services. As soon as a pregnancy is identified, eligible women are linked to Medicaid. Early and adequate prenatal care is encouraged and supported through FHB and Medicaid case management programs. The Babies Born Healthy Program received additional state funds for FY 2007 (\$500,000) to help meet the needs of low income women who do not have coverage for prenatal care services. Delivery of high risk infants at centers that are appropriate for their needs is encouraged through education efforts conducted by outreach educators in their perinatal region.

With the move to Medicaid managed care in Georgia, FHB programs have worked with the Department of Community Health and district staff to ensure coverage for needed MCH services by developing logic models and negotiating referral processes based on these models for major Public Health programs. In FFY 2007, FHB program will monitor how these changes in Medicaid impact client access to care.//2007//

/2008/ \$500,000 in supplemental state funds enabled approximately 900 additional clients to receive services.//2008//

/2009/ The OBO partnered with DCH to identify and develop a tool to evaluate the type and quality of care CMOs provide to Georgians. Reimbursement rates for services provided to Babies Born Healthy Program participants were increased to remain competitive with Medicaid.//2009//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL

Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	other	67	80.3	68.4
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Notes - 2010

Due to the loss of a Medicaid contract, we no longer receive Medicaid delivery claims files and therefore cannot link Medicaid delivery claims with Birth certificates. 2004 is the most current linkage available.

Narrative:

/2007/ All FHB programs aggressively link patients with available programs and entitlements they are eligible for to support the delivery of FHB services. As soon as a pregnancy is identified, eligible women are linked to Medicaid. Early and adequate prenatal care is encouraged and supported through FHB and Medicaid case management programs. The Babies Born Healthy Program received additional state funds for FY 2007 (\$500,000) to help meet the needs of low income women who do not have coverage for prenatal care services. Delivery of high risk infants at centers that are appropriate for their needs is encouraged through education efforts conducted by outreach educators in their perinatal region.

With the move to Medicaid managed care in Georgia, FHB programs have worked with the Department of Community Health and district staff to ensure coverage for needed MCH services and have developed logic models and negotiated referral process for major Public Health programs. In FFY 2007, FHB program will monitor how these changes in Medicaid impact client access to care.//2007//

/2008/ The FHB continues efforts, including collaboration with the Georgia Association of Family Practitioners and Georgia Chapter of the OB/GYN Society, to encourage linkage of pregnant women to early and adequate prenatal care. The Powerline, operated by Healthy Mothers Healthy Babies provides women with referral and contact information for low cost obstetrical providers. The FHB is also providing public health awareness and education based on CDC's recommended guidelines on preconception health, including encouraging women to make healthy lifestyle changes and to develop a reproductive life plan with their providers, in an effort to improve birth outcomes. The Babies Born Healthy program continues to assist uninsured and underinsured women access to quality prenatal services. High-risk perinatal families whose family income falls below 250% of federal poverty income guidelines are eligible for high-risk care at an RPC. A Birth Outcomes Symposium was held May 2007.

A statewide Birth Outcomes Symposium was held to provide a forum for national and local level experts to share information, expertise, and best practices on improving birth outcomes with statewide stakeholders. The symposium was held immediately before CDC's Preconception Expert panel in Atlanta which facilitated the participation of many panel members in the symposium. Symposium topics included an overview of CDC's preconception guidelines, using data effectively, reducing disparities, using social marketing, opportunities for Healthy Start, and the Interconception Care Program at Grady Hospital.//2008//

/2009/ In May 2007, the OBO convened a meeting between key Public Health staff and the state's regional perinatal centers to address issues of poor birth outcomes. Suggestions and recommendations were exchanged. Participants formed local committees to address birth outcomes in their regions and maintain open communication between Public Health and regional perinatal center staffs.//2009//

/2010/ An Infant Mortality Rate Summit was held on December 19, 2008 to enlist and promote collaborative support among Georgia's many stakeholders. The summit drew

more than 150 decision makers who recommended nearly 100 strategies that can be achieved through interagency collaboration.//2010//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2007	200
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Infants (0 to 1)	2007	235

Narrative:

FHB actively shares information on Medicaid and PeachCare for Kids with the community and public health staff through health fairs, community meetings and conferences. There also is FHB representation to Georgia's Covering Kids Program. The Covering Kids program, funded by the Kaiser Foundation, disseminates information and increases awareness of PeachCare for Kids and Medicaid programs in Georgia. In 2003, 164,384 infants under the age of one received Medicaid, about 12% of all Medicaid eligible recipients, and 93,684 pregnant women (7%) received Right from the Start Medicaid. Almost 1,800 infants under the age of one enrolled have enrolled in PeachCare for Kids (SCHIP).

/2007/ 6a (Infants) and 6b (Medicaid Children): In FY 2004, Medicaid served 1,442,773 Georgia residents. Of these, 991,906 (70%) were children: 172,693 babies under the age of 1, 331,067 children ages 1-5 and 488,146 children and youth ages 6-20 years old. Maternal and child health services, including prenatal and perinatal care, family planning, children's preventive health care through Health Check, assistance with children at risk, and help for children with physical and developmental problems, represented approximately 2% of total Medicaid benefit expenditures in FY 2004. Health Check services were provided to 422,039 children in FY 2004 with an average expenditure of \$105.53; 7,905 children received at risk case management services, 6,041 received early intervention case management, and 20,786 received children's intervention services.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2007	133
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP	YEAR	PERCENT OF POVERTY LEVEL

programs for infants (0 to 1), children, Medicaid and pregnant women.		SCHIP
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2007	235

Narrative:

2007/ 6a (Infants) and 6b (Medicaid Children): In FY 2004, Medicaid served 1,442,773 Georgia residents. Of these, 991,906 (70%) were children: 172,693 babies under the age of 1, 331,067 children ages 1-5 and 488,146 children and youth ages 6-20 years old. Maternal and child health services, including prenatal and perinatal care, family planning, children's preventive health care through Health Check, assistance with children at risk, and help for children with physical and developmental problems, represented approximately 2% of total Medicaid benefit expenditures in FY 2004. Health Check services were provided to 422,039 children in FY 2004 with an average expenditure of \$105.53; 7,905 children received at risk case management services, 6,041 received early intervention case management, and 20,786 received children's intervention services.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2007	200
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Pregnant Women		

Notes - 2010

Data is unavailable

Notes - 2010

Data is unavailable

Narrative:

6c: /2007/ Georgia exceeded its two-year enrollment goal in its first year of CHIP operations. It ranks fourth nationally in the number of enrolled children. Only California, New York, and Florida have enrolled more children. At the close of FY 2004, 244,070 children were enrolled in PeachCare with 1,865 (1%) under the age of 1, 68,179 (29%) ages 1-5, 123,007 (50%) ages 6-13, and 51,019 (21%) ages 14-19.

Georgia Healthy Families is a new program to provide health care services to Medicaid and PeachCare for Kids enrollees. The Department of Community Health has contracted with three private care management organizations (CMOs). Medicaid and PeachCare for Kids members are offered a choice of health plans and select the plan that best fits their needs. All children enrolled in PeachCare and children, pregnant women and women with breast or cervical cancer on Medicaid must participate in Georgia Healthy Families. Medicaid and PeachCare members in the Atlanta and Central region of the state were moved to Georgia Healthy Families on June 1, 2006.

Those living in East, North, Southeast and Southwest regions of the state will obtain Georgia Healthy Families services through September 1, 2006.

The goal of the Georgia's Covering Kids and Families Program (CFK) is to reduce the number of uninsured children and adults who are eligible for Medicaid and PeachCare for Kids, but are not enrolled. CFK is simplifying enrollment and renewal processes, coordinating existing healthcare and coverage programs, and educating professionals and the community at large about healthcare options. From November 2005 through January 2006, CFK held nine workshops statewide for professionals who work with the uninsured and underinsured in Georgia. The workshops provided information about all of Georgia's state-supported health coverage programs, including who is eligible, what is covered, and the application process. Participants included nurses, case managers, social workers, teachers, billing specialists, school administrators, school counselors, eligibility specialists, outreach workers, health educators, criminal justice professionals, and other health and social service providers. FHB programs continue to inform families, community members, and public health staff about Medicaid and PeachCare for Kids and to facilitate completion of the application process by eligible children and adults.//2007//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at	3	Yes

least every two years (like PRAMS)		
------------------------------------	--	--

Notes - 2010

Narrative:

DPH has implemented the Online Analytical Statistical Information System (OASIS), a suite of tools used to access the standardized health data repository. The standardized health data repository is currently populated with vital statistics, Georgia Comprehensive Cancer Registry, and population data.

FHB is responsible for the State Systems Development Initiative (SSDI), which was launched in 1993 to facilitate development of state level infrastructure, which in turn supports development of systems of care at the community level. SSDI has helped to establish or improve data linkages between birth records and infant death certificates, Medicaid eligibility or paid claims files, WIC eligibility files, and newborn screening files. In 2003, SSDI provided funding to create the Birth Defects Surveillance System. SSDI also funded Georgia's 2005 MCH needs assessment.

/2007/ OASIS is now populated with Hospital Discharge data. Youth Risk Behavior Survey data is also available by year, school level, and survey category.

The MCH Epidemiology Section annually links major data sets including infant birth and death certificates, birth certificates to Medicaid and WIC data, and birth certificates to Newborn Screening data. These linked sets are critical to evaluating MCH programs and providing data for surveillance and monitoring of the health status of the MCH population. In 2002, the Section established a statewide birth defects surveillance system. This data has been used for surveillance and monitoring of birth defects and to ensure children with birth defects are identified through the Children 1st system.

MCH Epi conducts the Pregnancy Risk Assessment Monitoring System (PRAMS). This data has been critical to understanding attitudes, behaviors, and experiences of women before, during, and after pregnancy. The data is used to monitor the Georgia's performance on issues such as breastfeeding, prenatal care experiences, and how babies are put to bed.

In Fall 2006, Georgia will deploy the Newborn Surveillance and Tracking System (NSTS), a consolidated web-based newborn surveillance and tracking system for the collection, management, and analysis of child (up to age five) health and case management information by approved private and public health care providers, and district, local, and state level program managers. NSTS will improve routine performance of program activities for Children 1st, UNHSI, GBDRIS, and Georgia Childhood Lead Poisoning Detection and Prevention. //2007//

/2008/ Georgia's Newborn Surveillance and Tracking system will be tested in August and implemented in fall 2007. The consolidated web-based system, designed for the surveillance, collection, tracking, analysis, and management of Children 1st, Universal Newborn Hearing Screening and Intervention, and Genetic and Metabolic Conditions, will greatly enhance the FHB and MCH staff's ability to integrate these critical activities that help to assure healthy outcomes for Georgia children//2008//

/2009/ SendSS (State Electronic Notifiable Disease Surveillance System) Newborn is the state's web-based population-based surveillance, collection, tracking, analysis, and management information system for at-risk infants and children throughout Georgia. On January 2, 2008, SendSS Newborn implemented Genetic and Metabolic Conditions functionality with Children 1st; Universal Newborn Hearing Screening and Intervention (UNHSI) programs began in May 2008. Genetic and Metabolic Conditions data is currently used to assure all children have been screened; future Children 1st and UNHSI data will greatly enhance the ability of Birth Outcomes and Epidemiology staffs to assure healthy outcomes for children.//2009//

/2010/ Georgia is estimated to have one of the three largest state sickle cell disease (SCD) populations in the nation, but the total number of Georgians with hemoglobinopathies is unknown, the number of health care providers able and willing to provide appropriate health care is inadequate, and the quality of care and health care outcomes are poorly defined. OBO's Newborn Screening Unit recently submitted a CDC grant application to implement the Georgia Hemoglobinopathy Surveillance System. It is designed to improve health services and outcomes for an estimated 7,000 -- 11,000 Georgians with SCD and other clinically symptomatic hemoglobinopathies by enhancing current newborn screening monitoring activities and by the creation of a new Georgia Hemoglobinopathy Surveillance Program (GA HSP) database with links to Georgia's newborn screening database. Proposed project objectives include determining the prevalence of hemoglobinopathies (SCD and thalassemia) across the lifespan in Georgia and the annual incidence of hemoglobinopathies in Georgia.

The Online Analytical Statistical Information System (OASIS) is a suite of tools (Web Queries, Mapping Tool, Animated Charting Tool, and Excel Cross-Tabulation Tool) designed, built, and maintained by the Health Planning and Assessment Unit (HPAU) (formerly OHIP) which are used to access DPH's standardized Health Data Repository. The mapping tool, designed by HPAU, is hosted by the University of Georgia's Carl Vinson Institute of Government. 2007 Vital Records, Hospital Discharge, and Emergency data are now available from the OASIS Mortality/Morbidity, Maternal/Child Health (MCH, Infant Death, and Emergency Room Visit Web Queries.)/2010//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2010

Narrative:

The Youth Risk Behavior Surveillance System (YRBS) provides information on Georgia adolescents' tobacco use, including cigarette smoking, cigars, and smokeless tobacco. The state's annual federal Substance Abuse Mental Health Services Administration (SAMHSA) Synar Report provides an overview of tobacco youth enforcement activities in Georgia, including the number of tobacco enforcement investigations that resulted in the illegal sale of a tobacco product to an underage youth.

FHB ICH staff have collaborated with the DPH Chronic Disease Branch/Tobacco Use Prevention Section and the Youth Empowerment Coordinator to provide collateral cessation messages and materials for tobacco and non-tobacco using youth. ICH has also collaborated with Chronic Disease Epidemiology to successfully implement and disseminate findings of the Youth Tobacco Survey in Georgia schools. Staff serve on the Tobacco-Free School work group, facilitated by the Youth DPH/Empowerment Coordinator.

The FHB AHYD staff have collaborated with the Tobacco Prevention Section and Epi to assure training and technical assistance to state, district, and AHYD staff on best practice approaches and to disseminate tobacco use statistics and researching findings to local communities. The FHB statewide network of 29 teen centers provide free tobacco screenings to adolescents ages 10 to 19. Tobacco use screenings represent the most requested of all individual screenings

conducted by teen centers, followed by substance abuse screenings and nutrition screening.

/2007/ The YRBS Survey is conducted in Georgia in odd calendar years to obtain information on risky behaviors, including tobacco use, among middle and high school students. The Youth Tobacco Survey, also conducted in odd years in Georgia, provides additional information on knowledge, attitudes, and beliefs related to tobacco and secondhand smoke exposure. Both surveys obtained representative data for middle and high school students in 2005. More than 1,900 middle school students and over 1,700 high school students participated, with overall response rates of 81% for middle schools and 77% for high schools. Data collected from these surveys are used to review, redesign, and evaluate existing preventive programs. Survey findings are published and distributed to schools, district public health offices, stakeholders, and legislators and presented at public health conferences and meetings. Findings are also made publicly available on the DPH website

AHYD staff serve on the Tobacco-Free School work group, facilitated by the Youth DPH/Empowerment Coordinator. FHB AHYD staff have also collaborated with the Tobacco Prevention Section and Epi to assure training and technical assistance to state, district, and AHYD staff on best practice approaches. Thirty-one teen centers provide free tobacco screenings to adolescents ages 10 to 19. Tobacco use screenings represent the most requested of all individual screenings conducted by teen centers, followed by substance abuse screenings and nutrition screenings.//2007//

/2008/ In 2007-2008, FHB will contract with Georgia State University to complete year 1 of a multi-year research study using the Behavior and Risk in Teens (BART) Survey. The study will gather data on DHR teen center programs and will provide information about the behaviors, risks, and health needs of teens participating in the 31 teen center programs. It is anticipated that the survey findings will verify program effectiveness, enhance model development, and improve the capacity of FHB teen center programs to target tobacco use.

/2009/ An Oral Health module is being developed for use in the next YRBS.//2009//

As part of its role in monitoring and assessing community health status as well as promoting healthy lifestyles, DPH publishes reports on a variety of topics, including tobacco use. Recent reports, available at <http://health.state.ga.us/publications/reports.asp>, include: 1) "Health Behaviors Among Georgia Youth in 1993 and 2003," which compares the results of the 1993 YRBS to those of the 2003 Georgia School Health Survey; 2) "The Tobacco Surveillance Report, GA 2004," which describes the array of surveillance activities pertaining to tobacco use in Georgia and provides information about the toll of tobacco on Georgians; and 3) "The Annual Synar Report," which reports Georgia's compliance with the Tobacco Regulation for the SAPT Block Grant and reporting provisions of the Public Health Service Act.//2008//

/2009/ Recent tobacco-related reports, available at <http://health.state.ga.us/epi/cdiee/tobaccouse.asp> include: "Tobacco Use Data Summary 2007" - provides updated information on overall burden of tobacco use; "Asthma & Secondhand Smoke Data Summary 2007" - describes impact of tobacco use on asthma; & "2005 Georgia Youth Tobacco Survey Report" - provides comprehensive data on various tobacco-related topics on middle and high school students.//2009//

IV. Priorities, Performance and Program Activities

A. Background and Overview

Over 100 statewide stakeholders participated in Georgia's FY 2006 MCH needs assessment process, providing feedback on the state's MCH system that the Family Health Branch used in selecting ten priorities that will help guide Branch activities over the next five years. (See II. Needs Assessment for additional stakeholder information.)

External Organizations:

Adoptive and Foster Parents Association of Georgia
Family Connection Partnership of Georgia
Family and community advocates
Georgia Academy of Family Physicians
Georgia Campaign for Adolescent Pregnancy Prevention
Georgia Chapter of the American Academy of Pediatrics
Georgia Governor's Council on Maternal and Infant Health
Georgia Health Policy Center of Georgia State University
Georgia Healthy Start Initiatives

- Atlanta Healthy Start
- Augusta-Richmond County Community Partnership Healthy Start
- Heart of Georgia Healthy Start

Georgia OB/GYN Society
Grady Hospital Nurse Midwifery Program
Grady Hospital Teen Services Program
Healthy Mothers/Healthy Babies Coalition of Georgia
Latin American Association
March of Dimes, Georgia Chapter
Mercer University School of Medicine, Family Medicine
Morehouse School of Medicine
Parent to Parent of Georgia
Voices for Georgia's Children

Other State-Level Agencies:

Department of Community Health */2010/ DPH moved to DCH effective July 1, 2009./2010//*
Department of Education
Department of Juvenile Justice
Division of Family and Children Services */2010/ Under recent DHR reorganization, DFCS is now located in the Department of Human Services./2010//*
Division of Mental Health, Developmental Disabilities, and Addictive Diseases */2010/ As of July 1, 2010, MHDDAD became the Department of Behavioral Health and Developmental Disabilities./2010//*

Within the Division of Public Health:

Program Coordinators
MCH Epidemiology Branch
North Georgia Public Health District

Georgia's needs assessment process has focused on the strengths, challenges, and opportunities within the State's MCH system. With a stronger infrastructure and system capacity built over the past five years, efforts during this five-year period will focus on strengthening the system and expanding services to meet new and emerging needs and concerns, working with MCH partners to maximize available resources. The shift from direct clinical service to case management and linkage to community-based services and the integration of categorical programs continues.

The FY 2006 needs assessment findings confirmed the overarching themes identified in the previous MCH needs assessment. These themes, described below, cut across MCH populations and levels of the pyramid. They provide the structure that has both guided the Branch's work for the last five years and will continue it over the next five years.

Population and Social Dynamics - With the changing "face" of Georgia, both in terms of size and diversity, issues related to allocation of resources and provision of relevant services must be confronted by policy-makers and service providers. Of particular note are concerns related to non-English speaking clients and limited English proficiency (LEP) clients, which necessitate changes in staff knowledge, skills, and abilities, and in staffing patterns, program content, and policies.

Prevention -- In all of its types -- primary, secondary and tertiary -- policies and programs need to be measured against a prevention yardstick. Preventable morbidity and mortality interventions start with the promotion of healthy lifestyles and safe behaviors. Over time, attainment of the FHB goals focused on these efforts will be reflected by improvement in Georgia's health status indicators.

Injury Prevention -- Primary prevention of both unintentional and intentional injuries is a key issue impacting all MCH population groups. Both in terms of morbidity and mortality, the toll of injury in the MCH population has been understressed and underfunded.

Coordination and Collaboration -- While the multiple partners and stakeholders in the MCH system are all working towards the same goal -- healthy and self sufficient families -- they tend to do so in a fragmented and isolated manner. Opportunities for coordination and collaboration exist in terms of program planning and implementation, personnel, research, data and advocacy.

Quality and Appropriate Service -- From planning to implementation to evaluation, the quality and appropriateness of services need to be at the center of attention. At the planning stage, activities should be based on existing data, focused research, and/or successfully evaluated models. Measures for quality assurance, benchmarking, and outcome and impact evaluation should be incorporated throughout. Training and technical assistance play key roles in assuring that services are of greatest benefit to clients and their families.

Access and Utilization -- A number of barriers exist related to service access and utilization, including lack of interpretative services, reliable transportation, knowledge about existing services, available and affordable child care, accurate perceptions regarding eligibility, oral health services, and mental health services. Enabling services and resources that facilitate consumer use of MCH system services are required to reach target populations. The lack of or inadequate availability of enabling services or resources is an ongoing concern, particularly in many rural areas of the state.

Data Systems -- A critical role exists for MCH in ensuring the collection and dissemination of quality data. Moreover, the data must be transformed into information and knowledge for state and local decision-makers and opinion-leaders. With the advances in information technology, greater opportunities exist to use this technology to support the collection, warehousing, and use of data in MCH planning, policy development, service delivery, and evaluation.

B. State Priorities

Georgia's needs assessment process and core themes (described in Section A. Priorities Background and Overview) validated and reaffirmed the state's MCH priority needs. These priorities, set forth below, are providing the framework guiding the state's MCH planning and policy development over the next five years.

Priority 1: Assure early access to prenatal and postpartum care for pregnant women.

Priority 2: Promote healthy nutritional behaviors and physical activity among the MCH population.

Priority 3: Reduce unintentional and intentional injury.

Priority 4: Improve oral health.

Priority 5: Promote preconceptional health.

Priority 6: Promote healthy behaviors and reduce risk-taking behaviors among adolescents.

Priority 7: Reduce health disparities among the MCH populations.

Priority 8: Assure a comprehensive system of age appropriate screening, referral, and follow-up for children from birth through age 21.

Priority 9: Assure an adequate MCH workforce.

Priority 10: Develop partnerships to support the overall health and well-being of the MCH population.

The process that was used to engage FHB program managers and planners in formulating the state performance measures is described in the needs assessment section of this block grant application. The relationship between the state's priority needs, national and state performance measures is identified below. (See attached file for priority tables.)

Relationship of Priority Needs to National and State Performance Measures:

/2007/ Based on Georgia's FY 2006 MCH Block Grant review discussions, revisions in the National Performance Measures, and review of the state's MCH priorities, the following changes have been made in Georgia State Performance Measures.

OLD STATE PERFORMANCE MEASURE #1: Percentage of pregnant women who abstain from smoking. (Changed because of its similarity to new NPM 15 - Percentage of women who smoke in the last three months of pregnancy.)

NEW STATE PERFORMANCE MEASURE #1: Percent of very low birth weight infants who are enrolled in HRIFU.

Increasing enrollment in HRIFU for infants born weighing less than 1,500 grams will help assure better health outcomes for these infants and lessen the incidence of emergency room visits and hospital admissions.

OLD STATE PERFORMANCE MEASURE #3: Rate of hospitalizations due to unintentional injuries among children ages one through five.

NEW STATE PERFORMANCE MEASURE #3: Rate of hospitalizations due to unintentional injuries among children ages one through four.

SPM 3 was changed from children ages one through five to one through four to better reflect standard age groupings collected at the state and national level.

Old State Performance Measure 7: Ratio of SIDS and SUID among African American infants to white infants.

New State Performance Measure 7: Rate of SIDS among African American infants.

SPM7 was changed because the ratio of African American SIDS rate to the white SIDS rate was unstable. Because the numbers are small, a slight increase or decrease by either group can significantly change the ratio. The source of the disparity is due to the high rate of SIDS among African Americans so the measure was changed to reflect that rate alone.

The concept of SUID was developed to apply to deaths that were sudden and unexplained but which did not incorporate both an autopsy and a complete death scene investigation. However, there is currently no consensus about definitions or how to classify deaths. In reviewing Child Fatality Review (CFR) data from the last several years, it has become apparent that the distinctions that local CFR teams make between what is SIDS and what is SUID are very subjective and somewhat arbitrary. Since the definitions and application of the terms are both unclear, making the distinction between SIDS and SUID does not provide added value at this time. Therefore, SPM 7 was changed from the "rate of SIDS and SUID" to "rate of SIDS." //2007//

Priority 1: Assure early access to prenatal and postpartum care

National Performance Measures (NPM):

- NPM 15: % of VLBW live births
- NPM 17: % of VLBW infants delivered at facilities for high-risk deliveries and neonates
- NPM 18: % of infants born to pregnant women receiving prenatal care beginning in 1st trimester

Proposed State Performance Measure (SPM):

- SPM 1: % of pregnant women who abstain from smoking

National Outcome Measures (NOM):

- NOM 1: Infant mortality rate per 1,000 live births
- NOM 2: Ratio of black infant mortality rate to white infant mortality rate
- NOM 3: Neonatal mortality rate per 1,000 live births
- NOM 4: Postneonatal mortality rate per 1,000 live births
- NOM 5: Perinatal mortality rate per 1,00 live births plus fetal deaths

Health Systems Capacity Indicator (HSCI):

- HSCI 4: % of women (15 through 44) with a live birth whose observed to expected prenatal visits are greater than or equal to 80% on Kotelchuck Index.

Healthy People 2010 Objectives (HP):

- HP Objective 16: MCH
- HP Objective 22: Physical Activity
- HP Objective 27-6: Increase smoking cessation during pregnancy

Priority 2: Promote healthy nutritional behaviors and physical activity

National Performance Measure:

- NPM 11: % of mothers who breastfeed their infants at hospital discharge

Proposed State Performance Measure:

- SPM 2: % of high school students who participate in physical activity for at least 20 minutes on 3 or more of the past 7 days

Health Systems Capacity Indicator:

- HSCI 9C: Ability to determine % of children who are obese or overweight

Healthy People 2010 Objective:

- HP Objective 16-19: Increase proportion of mothers who breastfeed their infants
- HP Objective 19: Nutrition and overweight

Priority 3: Reduce unintentional and intentional injuries

National Performance Measure:

- NPM 10: Rate of deaths to children aged 14 and younger caused by motor vehicle crashes

Proposed State Performance Measure:

- SPM 3: Rate of hospitalizations due to unintentional injuries among children ages one through four

National Outcome Measure:

- NOM 6: Child death rate per 100,000 children aged 1-14

Developmental Health Systems Indicators (DHSI):

- DHSI 3: Motor vehicle crashes ages 1-14
- DHSI 4: Hospitalizations ages 1-14 and 15-24

Healthy People 2010 Objective:

- HP Objective 15: Injury and Violence Prevention

Priority 4: Improve oral health

National Performance Measure:

- NPM 9: % of 3rd grade children who have received protective sealants

Proposed State Performance Measure:

- SPM 4: % of Medicaid and PeachCare (SCHIP) enrolled children who received preventive oral health services.

Health Systems Capacity Indicator:

- HSCI 7: % of EPSDT eligible children aged 6-9 who have received any dental service during the year

Healthy People 2010 Objective:

- HP Objective 21: Oral Health

Priority 5: Promote preconceptional health

Proposed State Performance Measure:

- SPM 5: % of women of reproductive age who consume at least 400 mcg of folic acid daily.

Developmental Health Systems Indicator:

- DHSI 5B: Rate per 1,000 women aged 20-44 with reported case of chlamydia

Healthy People 2010 Objectives:

- HP Objective 9-1: Increase proportion of pregnancies that are intended
- HP Objective 9-2: Reduce proportion of births occurring within 24 months of a previous birth
- HP Objective 9-6: Increase male involvement in pregnancy prevention and family planning efforts
- HP Objective 16-16: Increase proportion of pregnancies begun with optimum folic acid level
- HP Objective 25-9/10: Reduce congenital syphilis/reduce neonatal consequences from maternal STDs

Priority 6: Promote healthy behaviors and reduce risk-taking behaviors among adolescents

National Performance Measures:

- NPM 8: Birth rate for teenagers aged 15 through 17 years
- NPM 16: Rate of suicide deaths among youth aged 15-19

Proposed State Performance Measure:

- SPM 6: % of repeat births among adolescents aged 15-17 years old.

Health Systems Capacity Indicator:

- HSCI 9B: % of adolescents in grades 9 through 12 who reported using tobacco products in past month

Developmental Health Systems Indicator:

- DHSI 5A: Rate per 1,000 women aged 15-19 with a reported case of chlamydia

Healthy People 2010 Objectives:

- HP Objective 25-11: Increase proportion of adolescents who abstain from sexual intercourse or use condoms if currently sexually active
- HP Objective 18-2: Reduce the rate of suicide attempts by adolescents
- HP Objective 27-2: Reduce tobacco use by adolescents
- HP Objective 26-6: Reduce the proportion of adolescents who report that they rode, during the

previous 30 days, with a drinker who had been drinking alcohol

- HP Objective 26-9: Increase the age and proportion of adolescents who remain alcohol and drug free
- HP Objective 25-1: Reduce the proportion of adolescents and young adults with Chlamydia trachomatis infections

Priority 7: Reduce health disparities

National Outcome Measure:

- NPM 2: Ratio of black infant mortality rate to white infant mortality rate

Proposed State Performance Measure:

- SPM 7: Rate of SIDS among African American infants.

Health Systems Capacity Indicator: 5

- HSCI 5: Medicaid and non-Medicaid LBW, infant mortality, entry into prenatal care in 1st trimester, and adequate perinatal care

Priority 8: Assure comprehensive system of age appropriate screening, referral and follow-up

National Performance Measures:

- NPM 1: % of newborns who are screened and confirmed with conditions mandated by their state-sponsored newborn screening programs
- NPM 2: % of newborns screened for hearing impairment before hospital discharge
- NPM 3: % of CSHCN age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.
- NPM 5: % of CSHCN age 0 to 18 whose families report the community-based service systems are organized so they can use them easily.
- NPM 6: % of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life.
- NPM 12: % of newborns that have been screened for hearing before hospital discharge.

Proposed State Performance Measure:

- SPM 8: % of Medicaid children who have had a developmental screening.

Health Systems Capacity Indicators:

- HSCI 2: % of Medicaid enrollees whose age is less than one year who received at least one initial or periodic screen
- HSCI 3: % of SCHIP enrollees whose age is less than one year who received at least one initial or periodic screen

Healthy People 2010 Objectives:

- HP Objective 28: Vision and hearing
- HP Objective 18-8: Increase proportion of juvenile justice facilities that screen new admissions for mental health problems
- HP Objective 16-20: Ensure appropriate newborn bloodspot screening, follow up testing, and referral to services

Priority 9: Assure adequate MCH workforce

Proposed State Performance Measure:

- SPM 9: % of MCH local level staff that receive basic Public Health training.

Healthy People 2010 Objective:

- HP Objective 23-8: Increase the public health agencies that incorporate specific competencies in the essential public health services into personnel systems.

Priority 10: Develop partnerships to support overall health and well-being of MCH population

National Performance Measures: 1, 2, 5, 7, 8, 9, 11, 12, 13, 15, 16, 18

Proposed State Performance Measure:

- SPM 10: The extent to which partnerships that support Early Childhood Comprehensive Systems (ECCS) are effective. /2007/ See Section IV Attachment for new SPM rating scale//2007//

National Outcome Measures:

- NOM 1: Infant mortality rate per 1,000 live births

- NOM 2: Ratio of black infant mortality rate to white infant mortality rate
- NOM 3: Neonatal mortality rate per 1,000 live births
- NOM 4: Postneonatal mortality rate per 1,000 live births
- NOM 5: Perinatal mortality rate per 1,00 live births plus fetal deaths
- NOM 6: Child death rate per 100,000 children aged 1-14

An attachment is included in this section.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	214	216	256	210	210
Denominator	214	216	256	210	210
Data Source					Georgia NBS Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	2010	2011	2012	2013
Annual Performance Objective	100	100	100	100	100

Notes - 2008

Data for 2008 currently unavailable and will be provided in 2011.

Notes - 2006

Numbers for 2003 were incorrect and have been updated. The data used is SLAITS data as this is the only population-based source data available in Georgia.

a. Last Year's Accomplishments

Initiated screening for MCADD in January 2005. Four babies have been diagnosed to date and are in treatment. (Population-Based)

Released news release to media (January 24, 2005), "DHR adds new screening test for newborns that can save lives." (Enabling)

Revised newborn screening rules to change time of collection from 48 to 24 hours. Rules will become effective when filed in Secretary of State's Office (expected to be summer 2005). (Infrastructure)

Appointed (NBS Advisory Committee) a task force to make recommendations concerning newborn screening for cystic fibrosis. (Infrastructure)

Recommended (NBS Advisory Committee) that screening for cystic fibrosis and the remaining 15 tandem mass spectrometry (TMS) conditions be added to the panel. (Infrastructure)

Appropriated (Georgia Legislature) \$1.6 million to support newborn screening for MCADD and biotinidase deficiency. (Infrastructure)

Conducted cost analysis of newborn screening as basis for developing a newborn screening fee schedule. (Infrastructure)

Completed and distributed educational CD and pocket reference card to providers. (Enabling)

Updated and enhanced newborn screening web page
(<http://health.state.ga.us/programs/nwmscd/>). (Enabling)

Referred all babies with abnormal screening test results to follow-up contractors for retrieval and diagnosis. (Direct Medical Care)

Referred all babies with a diagnosed disease to Children 1st. (Enabling)

Provided assistance to providers requesting metabolic results, answering provider questions on follow-up agencies (i.e., Sickle Cell Foundation) and clarifying terminologies, using the Newborn Screening Reference Manual. (Infrastructure)

Participated in Newborn Screening workgroup, advisory group, and Epi meeting sessions. (Infrastructure)

Implemented pilot project to examine delays associated with unsatisfactory specimens and suitability of testing. (Infrastructure)

Developed proposed fee system to support NBS. (Infrastructure)

Continued to refine the follow-up documentation program. (Infrastructure)

Continued to send hospital data reports. (Infrastructure)

Distributed posters to promote parent awareness of newborn screening. (Population-Based)

Continued to assist hospitals with technical assistance and education on newborn screening. (Infrastructure)

Legislation enacted to add an additional 16 conditions (15 metabolic and cystic fibrosis) to the test panel. Rules revised and awareness and educational programs developed and implemented. Web page updated. (Infrastructure)

Further developed genetic screening system to ensure monitoring and tracking of every newborn throughout the system, case management of all positive results, and evaluation of all components, i.e., screening, short term follow-up, diagnosis, treatment/management, evaluation, and long-term outcomes. (Infrastructure)

In January 2007, expanded the Newborn Screening Panel from 13 to 29 disorders, including cystic fibrosis. (Direct care, enabling)

Updated a physician pocket reference and parent brochure to include the new disorders. (Enabling)

Instituted \$40 per infant screening charge in January 2007. Between January and April, \$472,000 billed and \$423,000 received. (Infrastructure)

Tested 55,550 specimens in SFY 2007 after implementation of expanded screening. (Direct care)

Made referrals to NBS follow up programs. (Direct care)

Established (DHR Commissioner and DPH) newborn screening as a "wildly important goal" (WIG) focus area. WIG goals include: 1) 100% of newborns receive an adequate newborn screening test no earlier than 24 hours and no later than 1 week of birth (NSB results are being matched to birth records to determine which infants have not been screened); 2) 100% of infants with positive screens receive prompt and appropriate follow-up testing (data elements to measure progress toward this goal are being defined); and 3) all newborns diagnosed with a metabolic, endocrine, or hemoglobin disease are entered into and maintained on appropriate medical therapy.) (Infrastructure)

Incorporated the ability to readily track the data necessary to measure WIG progress into the SENDSS-Newborn, Georgia's surveillance and tracking system. Two of the three follow-up contractors have begun using this system to input follow-up data; the third is expected to begin use in the near future. (Infrastructure)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitoring the referrals of infants diagnosed with metabolic and hemoglobinopathies to appropriate CSHCN programs (BCW, CMS, HRIFU).				X
2. Including funds for special formulas in Metabolic Follow Up contract.			X	
3. Providing specialized formulas, as needed.			X	
4. Collaborating with Newborn Screening program regarding policies, procedures and development of SENDSS Newborn.				X
5. Continuing MCH Epidemiology linkage of newborn screening records with Electronic Birth Certificates.				X
6. Continuing to provide access to and monitor hospital reports to identify each hospital's unsatisfactory specimens.				X
7. Continuing to follow up all abnormal screening test results contractually. (All infants diagnosed with a disorder are referred to Children 1st by the follow up program.)			X	
8.				
9.				
10.				

b. Current Activities

Using Medical College of Georgia (MCG) and Grady Sickle Cell Disease Centers as follow-up contractors for abnormal hemoglobin results, are performing follow-up activities in the Genetics module of SENDSS Newborn. Emory Genetics, the follow-up contractor for the remaining NBS disorders, is also feeding detailed data into the system on a regular basis. Hospital performance reports that monitor collection and transport quality have been built into SENDSS Newborn so that hospitals can view their data at will. (Direct care, infrastructure)

c. Plan for the Coming Year

Implement strategies to improve the ability to match birth records to screening tests.

Implement a system for active follow-up of unsatisfactory newborn screening specimens.

Develop and implement a training and education for the improvement of hospital specimen collection performance.

Revise rules and regulations to include performance standards and measures.

Update NBS website.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	0	60.8	60.8	60.8	55
Annual Indicator	60.8	60.8	60.8	54	54
Numerator					
Denominator					
Data Source					SLAITS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	2010	2011	2012	2013
Annual Performance Objective	56	57	58	59	59

Notes - 2008

Data is from the 2005-2006 SLAITS survey. Data for CY 2008 will not be available until the 2007-2008 survey is conducted and results are posted.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006

The SLAITS survey was conducted from April 2006 to December 2006. The results have not yet been published.

a. Last Year's Accomplishments

Completed statewide CMS family satisfaction survey. Results indicated that 93 percent of families strongly agreed or agreed with regard to satisfaction with: 1) information to manage child's care, plan of care, and care coordinators; 2) ease of access to services; and 3) actual services. (Enabling)

Held (public health districts) parent involvement activities, such as family picnics, local ICC meetings (BCW and CMS), parent conferences, and Family Connection meetings. (Enabling)

Conducted parent interviews during on-site district QA visits. Results indicate high level of satisfaction with CMS services and programs. (Enabling)

Presented family experiences and stories, presented by parents of CMS enrolled children, at April 2005 CMS Coordinators' meeting. (Enabling)

Expanded the Interagency Case Management System Project (ICMSP) to Chatham County and continued ICMSP in Bartow, Floyd, and Walker Counties. (Infrastructure)

Exhibited CSN program materials during Families First Conference in September 2007. (Enabling)

At local level, held ongoing events to provide families the opportunity to partner in decision-making. (Enabling)

Interviewed 10-15 families in each district as part of ongoing district QA process. Families overwhelmingly have reported high satisfaction with the care coordination services they receive from CMS staff and from the program. Findings from a statewide family satisfaction survey of 650 families indicate 95% strongly agreed/agreed they were satisfied with CMS services provided. (Infrastructure)

Collected BCW family outcome data from 1,180 families as they exited BCW. Findings indicate 90% reported early intervention helped them know their rights; 92% reported that early intervention helped them communicate their child's needs effectively; and 91% indicated they were able to help their children develop and learn. (Infrastructure)

Redesigned BCW program. Have held stakeholder meetings to obtain input on restructuring. Families have participated in stakeholder meetings. (Infrastructure, Enabling)

At local level, examples of district activities included family member presentations at district staff meetings. (Enabling)

At the health district level, participated in Family Connection initiatives. Staff are also involved with Head Start programs. Both Family Connection and Head Start have parent involvement. (Infrastructure)

Conducted ongoing assessment via family satisfaction surveys. CMS quality assurance programmatic and fiscal review activities are conducted on a three-year cycle. (Infrastructure)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuing family participation through development of CMS care coordination plan of care.		X		
2. Conducting CMS family satisfaction survey statewide every three years as well as an ongoing survey as part of CMS quality assurance programmatic/fiscal review (three year cycle).				X
3.				
4.				

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Continuing to involve families in the development of client plans of care (POC) and needs lists. Families are encouraged to determine the priority for the child and his/her needs. (Enabling)

At the health district level, continuing to attend and support local council meetings for BCW and CMSs and their parent members. (Infrastructure)

Continuing to support clients and their families in attending diabetes and asthma camps. Some districts conduct asthma camps on site. (Enabling)

At the health district level, participating in Family Connection initiatives. Staff are also involved with Head Start programs. Both Family Connection and Head Start have parent involvement. (Infrastructure)

c. Plan for the Coming Year

Finalize CMS quality assurance programmatic and fiscal review process revisions. The improved quality assurance process will include participation of a parent consultant on the review team.

Initiate development of a statewide plan to develop family action and support teams (FAST) in each district. Goals include providing families with special needs children the opportunity to review and advise current CMS policies and procedures; facilitating families working together for support, information, and networking; and increasing public awareness and cultural caring. A representative from each of the district FAST groups or family advisory councils will advise the CMS Advisory Council on plan to roll out FAST.

Conduct ongoing assessment using family satisfaction surveys. CMS quality assurance programmatic and fiscal review activities are conducted on a three-year cycle.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	0	50	50	51	51
Annual Indicator	49.4	49.4	49.4	47.3	47.3
Numerator					
Denominator					
Data Source					SLAITS
Check this box if you cannot report the numerator because					
1. There are fewer than 5 events over the last year,					

and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	2010	2011	2012	2013
Annual Performance Objective	51	51	51	51	51

Notes - 2008

Data is from the 2005-2006 SLAITS survey. Data for CY 2008 will not be available until the 2007-2008 survey is conducted and results are posted.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006

The SLAITS survey was conducted from April 2006 to December 2006. The results have not yet been published.

a. Last Year's Accomplishments

Continued to facilitate CMS program enrollees accessing a medical home. (Direct Medical Care)

Linked infants to needed audiological diagnostic services utilizing state's Universal Newborn Hearing Screen and Intervention Program. (Direct Medical Care)

Continued to collaborate on Medical Home Component of Early Childhood Comprehensive Systems grant. (Infrastructure)

Continued to link CSN children with medically necessary specialty services, coordinating linkage with child's medical home/primary care provider, including audiological diagnostic services. (Direct medical care)

Educated families new to Medicaid managed care process to assist them in navigating the services and regulations of a Care Management Organization (CMO). With implementation of Georgia's Medicaid managed care system and the family's choice of a CMO, the PCP member of the selected CMO is the child's "medical home." (Enabling)

Worked to include "dental home referral" on WIC Assessment and Certification form for infants at 12 months old. Oral health education/training on serving CSN is provided to dental professionals through meetings, conferences, and shared publications. (Enabling)

As part of ECCS Medical and Dental Home Work Group activities, conducted presentations to the Parent Leadership Coalition and at Early Child Care Providers Conference to increase family awareness about the importance of children having a medical and dental home. (Enabling)

Through 6 Regional Perinatal Centers (RPC), conducted Developmental Follow Up Clinics, using standardized follow up protocols, for the first two years of life for infants discharged from RPC nurseries. (Direct medical care)

Redesigned BCW program. Have held stakeholder meetings to obtain input on restructuring. Families have participated in stakeholder meetings. (Infrastructure, Enabling)

Received information from parents at State ICC meeting on impact of Medicaid managed care

and Care Maintenance Organizations on their children's therapies, treatments, and access to care. (Enabling)

Exhibited CSN program materials during annual American Academy of Pediatrics -- Georgia Chapter and Georgia Academy of Family Physicians meetings. (Enabling)

Presented on "medical/dental home" at annual Bright From the Start Conference." (Enabling)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuing CYSN participation in FHB Early Childhood Comprehensive Systems (ECCS) grant. (One component of the grant is the planning and implementation of infrastructure for statewide Medical Home Initiative for all children.)				X
2. Continuing to facilitate CYSN program enrollees accessing medical home.	X			
3. Continuing to document the percentage of CYSN enrollees who have documented medical home.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

On admission to CMS program and annually, assessing whether or not a child has a medical home. (Direct care)

Assessing children referred to BCW program for presence of a primary care provider (PCP). BCW program service coordinators regularly review medical home information and presence of a medical home is include as part of the individual family service plan. (Direct care)

Continuing to refer clients without a primary care provider (PCP) to a provider. Ninety-six percent of CMS clients have a PCP. (Direct care)

Co-led Georgia Early Child Comprehensive System (ECCS) workgroup on access to medical and dental home. (Infrastructure)

Populating web-based ECCS clearinghouse with information and web links on the importance of medical and dental homes for children. (Infrastructure)

c. Plan for the Coming Year

Maintain status and continue to refer CMS clients without a PCP to a provider.

Continue to help populate ECCS clearinghouse with medical and dental home web links.

Continue to notify PCP of receipt of referral to the CMS program.

Continue to refer children seen in pediatric specialty clinics to PCP for routine care and preventative services.

Interview families annually and remind them that of the importance of a PCP and routine care. Provide care coordination in scheduling appointments (when needed) with the PCP to facilitate the family's follow up with the child's PCP.

Collaborate with special needs child's PCP and foster the continuation of physician recommended services, assisting the family and providing care coordination as needed.

Participate as a liaison between the PCP and the child and his/her family. Advocate to ensure parents' and client's participation in the PCP plan of care for the child.

Continue to monitor follow up for routine care by PCP via client interview.

Investigate the feasibility of establishing a contract with the Georgia Chapter of the American Academy of Pediatrics for the promotion of medical home recommendations via education about routine care for special needs children at their medical home and referral to and from CMS for care of the special needs pediatric population.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	0	57	57	58	62
Annual Indicator	56.4	56.4	56.4	61.2	61.2
Numerator					
Denominator					
Data Source					SLAITS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	2010	2011	2012	2013
Annual Performance Objective	62	62	62	62	62

Notes - 2008

Data is from the 2005-2006 SLAITS survey. Data for CY 2008 will not be available until the 2007-2008 survey is conducted and results are posted.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006

The SLAITS survey was conducted from April 2006 to December 2006. The results have not yet been published.

a. Last Year's Accomplishments

Continued to monitor payment sources for services (i.e., types of insurance) and refer families to potential resources. (Infrastructure)

Developed plan to identify service needs of families not covered by insurance. (Infrastructure)

Continued to work with Medicaid and PeachCare to link all eligible children. 64% of CMS clients had Medicaid, 8% PeachCare, 12% private insurance, and 1% Tricare. (Infrastructure)

Collaborated with MHDDAD and DFCS to implement funding for children who are no longer eligible for the Medicaid Deeming Waiver. (Infrastructure)

Met with APS Health Care representatives (Administrative Service Organization, Georgia Medicaid Managed Care Program) to obtain information on how APS services fit into the existing Medicaid and CMO services offered to Part C and Title V CSHCN. (Enabling)

Provided CSHCN coordinators with a presentation by APS HealthCare regarding APS services available for CSHCN clients and families. (Enabling)

Received information from parents at State ICC meeting on impact of Medicaid managed care and Care Maintenance Organizations on their children's therapies, treatments, and access to care. (Enabling)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuing to monitor payment sources for services (i.e., types of insurance) and refer families to potential resources.				X
2. Developing plan to identify service needs of families not covered by insurance.				X
3. Continuing to work with Medicaid and PeachCare to link all eligible children.				X
4. Collaborating with the Governor's Office of Highway Safety on middle childhood initiative to provide primary education to children under age 14 on motor vehicle safety.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Continuing to assess the level of health care covered by insurance or Medicaid of all clients entering the CMS arena (some clients are not admitted to the program based on diagnosis or income, but their health care coverage is still assessed).

Continuing to assist CMS clients with applying for insurance based on eligibility. Of 8,491 clients in CMS, approximately 64% have Medicaid, 6.5% (down by 1.5% from the previous year) have

PeachCare for Kids, 12% have private insurance, 1% have TriCare (down by 1% from the previous year), and 16% only have CMS. (Enabling)

c. Plan for the Coming Year

Continue to assist clients with insurance applications, based on client eligibility.

Continue to provide clients with supplemental funding, following CMS policies, for medical care, medications, and equipment.

Continue to provide care coordination, including referral to resource agencies, including agencies that may help reduce the overall cost families pay out of pocket, to facilitate the most effective use of family financial resources and provide health care for the child with special needs.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	0	75	75	76	92
Annual Indicator	74.9	74.9	74.9	91	91
Numerator					
Denominator					
Data Source					SLAITS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	2010	2011	2012	2013
Annual Performance Objective	92	92	92	92	92

Notes - 2008

Data is from the 2005-2006 SLAITS survey. Data for CY 2008 will not be available until the 2007-2008 survey is conducted and results are posted.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006

The SLAITS survey was conducted from April 2006 to December 2006. The results have not yet been published.

a. Last Year's Accomplishments

Completed CMS statewide family satisfaction survey. Results indicate 94 percent of respondents said they had a way of getting to the services and that it was easy to get to the location where the services were offered. Approximately 93 percent of respondents agreed or strongly agreed that services were offered at convenient times. (Infrastructure)

At the local level in rural areas of the state, continued to conduct clinics in specialty areas for CSCHN to insure access in communities lacking specialty services. (Direct Health Care)

Used telemedicine in one rural health district to provide community based services for CSCHN. (Direct Health Care)

Worked with BCW and ICH Health Program Coordinator to assess training and technical assistance and resource sharing needs to assure collaboration between funded activities and among district MCH activities. (Infrastructure)

Completed CMS statewide survey. 83% of families participating in the CMS survey indicated they strongly agreed/agreed that the community-based services are organized so that they can access them easily. Continued to work on integrating services for CSCHNs. (Infrastructure)

Continued to facilitate client and family use of all available service systems. (Enabling)

Redesigned BCW program. Have held stakeholder meetings to obtain input on restructuring. Families have participated in stakeholder meetings. (Infrastructure, Enabling)

Received information from parents at State ICC meeting on impact of Medicaid managed care and Care Maintenance Organizations on their children's therapies, treatments, and access to care. (Enabling)

Created the Georgia Families Matter website to guide and inform families and professionals of changes in Georgia's early intervention system. (Enabling)

Revised and updated early intervention fact sheets. (Enabling)

Used telemedicine in one rural health district to provide community based services for CSCHN. (Direct Health Care)

Redesigned BCW program. Have held stakeholder meetings to obtain input on restructuring. Families have participated in stakeholder meetings. (Infrastructure, Enabling)

Received information from parents at State ICC meeting on impact of Medicaid managed care and Care Maintenance Organizations on their children's therapies, treatments, and access to care. (Enabling)

Posted Georgia data from the 2005-2006 National Survey of Children with Special Health Care Needs posted on the CMS web site. Articles about the survey and Georgia specific data have been published in the GA AAP and GAFFP newsletters. (Infrastructure)

Completed CMS statewide survey. Eighty-three percent (83%) of families participating in the CMS survey indicated they strongly agreed/agreed that the community-based services are organized so that they can access them easily. Continued to work on integrating services for CSCHNs. (Infrastructure)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service
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	DHC	ES	PBS	IB
1. Gathering data from other states and MCHB sponsored contracts that have completed previous work in this area.				X
2. Conducting CMS family satisfaction survey statewide every three years as well as an ongoing survey as part of CMS quality assurance programmatic/fiscal review (three year cycle).				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Updated CMS brochure and translated it into Spanish. (Enabling)

Updated the CMS and CYNS web sites. (Infrastructure)

Continuing to work on integrating services for CSHCNs. (Infrastructure)

At the local level in rural areas of the state, continuing to conduct clinics in specialty areas for CSHCN to insure access in communities lacking specialty services. (Direct Health Care)

Using telemedicine in one rural health district to provide community-based services for CSHCN. (Direct Health Care)

Working with BCW and ICH Health Program Coordinator to assess training, technical assistance, and resource sharing needs to assure collaboration between funded activities and among district MCH activities. (Infrastructure)

Completed CMS statewide survey. Eighty-three percent of families participating in the survey indicated they strongly agreed/agreed that the community-based services are organized so that they can access them easily. Continued to work to integrate services for CSHCNs. (Infrastructure)

Continued to facilitate client and family use of all available service systems. (Enabling)

Held stakeholder meetings to obtain input on restructuring. Families have participated in stakeholder meetings. (Infrastructure, Enabling)

c. Plan for the Coming Year

Continue to develop family advisory/support groups for CMS in each district.

Assess the feasibility of allocation of funds to each district to be used specifically to assist in the addition of a paid parent consultant in each district.

Task family support groups with making recommendations regarding expanding accessibility of the community CMS services.

Provide more eligibility information for CYNS programs on DHR web site.

Regularly update state DHR CYSN web site information.

Continue to circulate program brochures to healthcare providers in offices and at conferences of various professional organizations (i.e., American Academy of Family Practice, American Academy of Pediatrics, etc.), DFCS, and other community agencies.

Continue to conduct district/community outreach activities (e.g., health fairs, conferences, and family education sessions) regarding children and youth with special needs.

Continue to work with Perinatal Health, Adolescent Health, Asthma, Nutrition, and Tobacco programs in establishing and consolidating efforts to provide community service information to children and their families.

Establish partnerships with new groups in the state community who have an interest in children with special needs.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	0	6	6	6	38
Annual Indicator	5.8	5.8	5.8	37	37
Numerator					
Denominator					
Data Source					SLAITS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	2010	2011	2012	2013
Annual Performance Objective	38	38	38	38	38

Notes - 2008

Data is from the 2005-2006 SLAITS survey. Data for CY 2008 will not be available until the 2007-2008 survey is conducted and results are posted.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006

The SLAITS survey was conducted from April 2006 to December 2006. The results have not yet been published.

a. Last Year's Accomplishments

Worked on transition manual to facilitate the consistency and ease of producing a transition plan for clients. Currently 66.5% of clients 16-21 years of age have a transition plan. (Infrastructure)

Served as member of Georgia Department of Education Steering Committee that developed transition guidelines for the education setting. (Infrastructure)

Worked with BCW and ICH/School Health Program Coordinator to assess training and technical assistance and resource sharing needs to assure collaboration between funded activities and among district MCH activities. (Infrastructure)

Continued to ensure CSHCN clients 16-21 years of age have a transition plan as part of care coordination plan of care; 97% of CMS clients age 16-21 have a plan. (Enabling)

Paid a family member as a consultant to provide input on draft CMS Transition Plan. (Enabling)

Obtained Division approval for CMS Transition Manual, "Transition Planning for Adolescents with Special Health Care Needs and Disabilities." (Infrastructure)

Implemented use of CMS Transition Manual. (Infrastructure)

Assessed district staff need for further training on CMS Transition Manual use. (Infrastructure)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuing to provide literature and updates on transition services to district coordinators.				X
2. Disseminating transition materials to district coordinators to use with clients and families.				X
3. Collecting data on percent of clients and families with a transitional plan of care.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Continuing to develop transition plans for CMS clients aged 16 to 21; 96% of CMS clients in this age range had a transition plan. (Direct care)

Continuing to monitor transitioning planning data quarterly in all districts. (Infrastructure)

Using CMS Transition Manual in each of the 18 health districts for the 16-21 year old population of children with special needs. (Infrastructure)

Assessed district staff need for further training on CMS Transition Manual use. Administered statewide survey of district CMS professional staff to determine training needs. (Infrastructure)

Participating in Healthy and Ready to Work (HRTW) topical calls regarding CSHCN and transition. (Enabling)

c. Plan for the Coming Year

Continue to monitor the percentage of clients 16 to 21 years of age with a transition plan quarterly.

Conduct a statewide training for CMS nursing staff on transition planning.

Conduct follow-up evaluation and continued assessment of training monitoring data for reported increase in percentage of transition plans.

Facilitate staff development and implementation of transition appointment scheduling strategies with clients and their families.

Require that all CMS family advocacy councils/groups receive transition planning training.

Obtain input from CMS family advocacy councils/groups on how to improve the transition planning process.

Continue to participate in HRTW topical calls regarding CSHCN and transition.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	85	85	85	85	85
Annual Indicator	82	82.4	82.4	81.3	79.6
Numerator					
Denominator					
Data Source					NIS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	85	85	85	85	85

Notes - 2008

The Data comes from the National Immunizations Survey (NIS); numerator and denominator would not be meaningful since this is survey data. Data from previous years has been updated to

reflect calendar year. For 2000-2002, the data reflects 4:3:1:3:3 series. For 2003-2004 the data reflects 4:3:1:3:3:1 series. For 2007-2008 data reflects 4:3:1:3:3:1 series.

Notes - 2007

The Data comes from the National Immunizations Survey (NIS); numerator and denominator would not be meaningful since this is survey data

Notes - 2006

The Data comes from the National Immunizations Survey (NIS); numerator and denominator would not be meaningful since this is survey data. Data from previous years has been updated to reflect calendar year. For 2000-2002, the data reflects 4:3:1:3:3 series. For 2003-2004 the data reflects 4:3:1:3:3:1 series. 2006 NIS survey is not yet available.

a. Last Year's Accomplishments

Monitored health status of at-risk children birth to age 5 through Children 1st. Promoted immunization through all activities that target young children (Children 1st, Well Child, Healthy Child Care Georgia, etc.). During the Children 1st family assessment process, encouraged families to keep child immunized. (Population-Based)

Participated in quarterly Immunization Coordinators meetings, sharing pertinent childhood immunization information with child health coordinators and ICH team. (Enabling)

Discussed deficiencies, identified during Well Child Reviews in county health departments and private pediatric practices, with providers. Complete documentation and submit report to DCH for appropriate action. (Infrastructure)

Through Children 1st and the Electronic Birth Certificate (EBC) review, infants with positive Hep B were referred to the Immunization Program to ensure appropriate follow-up services. (Population-Based)

Monitored the immunization status of all children 19-35 months of age using data collected through the annual statewide Georgia Immunization Study. Disseminated results to health care providers that immunized children with state provided vaccines and to other program stakeholders. (Population-Based)

Provided education to health care providers about the importance of assuring immunizations are up-to-date for all children. Collaborated with educational partners to expand the provider community receiving education and to increase health care provider participation and use of state provided vaccines. (Enabling)

Identified missed immunization opportunities during quality assurance site visits to clinics and provider offices. Provided feedback to healthcare staff to reduce or avoid missed opportunities. (Infrastructure)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participating in quarterly immunization coordinators meetings.				X
2. Promoting childhood immunizations during all activities that target young children, i.e., Children 1st, Healthy Childcare Georgia, Health Check, etc.			X	
3. Including immunization assessment during desk audits and in programs, e.g., WIC.				X

4. Collaborating with the Department of Community Health and the American Academy of Pediatrics – Georgia Chapter to assure that private providers offer appropriate services, including immunizations and developmental screenings to children who are enrol				X
5. Monitoring health status of at-risk children birth to age 5 through Children 1st.			X	
6. Assessing immunization information at childcare facilities to ensure children are protected against vaccine preventable disease.			X	
7.				
8.				
9.				
10.				

b. Current Activities

Increased computer interfaces available for providers to download immunization data directly into GRITS, enhancing the availability of vaccine records. (Infrastructure)

Enrolled additional childcare organizations in GRITS to view immunization records and refer non-compliant children to health care providers for needed vaccines. (Infrastructure)

Assessed private provider immunization records using CoCASA software to increase vaccination levels by measuring rates against national standards. (Infrastructure)

Provided education to provider groups through exhibits and conferences to increase their understanding of the national recommendations and state requirements for immunizations. (Enabling)

Ensured that local health department staff are working with WIC clinics to assess client immunization records and refer them to follow up care with health care provider. (Infrastructure)

c. Plan for the Coming Year

Assess health care provider vaccination processes using the Assessment, Feedback, Information, and Exchange (AFIX) methods and develop strategies to prevent missed vaccination opportunities and increase vaccination levels.

Work with partner organizations to target childcare groups with quick immunization reference guides and parent educational materials.

Revise guidance for local health department staff working with childcare provider sites to review immunization records and ensure that all children have valid immunization documentation.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	33	29	29	28	28

Annual Indicator	29.7	28.0	28.0	29.9	29.4
Numerator	5404	5260	5260	5785	5756
Denominator	182217	187616	187616	193272	195685
Data Source					Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	27	27	26	25	25

Notes - 2006

Data for FY 2006 is not yet available and will be provided in the FY 2009 MCHBG.

a. Last Year's Accomplishments

Implemented new DHR Adolescent Pregnancy and STD Prevention Services Policy for Teen Centers, placing abstinence education as the key risk reduction strategy/message. The DHR policy, implemented September 2004, requires establishment of parent advisory councils for each funded center and that abstinence education represent 50 percent of all sexuality education implemented through AHYD funded teen centers. Policy mandates teen center use of DPH protocols for contraceptive distribution, including abstinence education counseling, encouraging parental involvement, and signed consent. The new policy also mandates uses of best practice approaches. (Infrastructure)

Collaborated with DHR Epi Section to plan and implement Phase I of an outcome evaluation that includes a behavioral self-assessment survey of risk taking behaviors among teen center participants (BART). A survey instrument pilot test in five teen center sites was completed in April 2005. (Infrastructure)

Implemented three training programs for 60 abstinence education subcontractors, state and district health staff, and public information officers to review, plan and, and effectively implement statewide abstinence education awareness campaign message, Abstinence, Attractive In So Many Ways, and marketing activities. (Enabling)

Reprinted and distributed 22,780 English (90%) and Spanish (10%) language abstinence education campaign posters. (Enabling)

Premiered "Empowering Congregations as Resources for Adolescent Health and Youth Development" CD for faith leaders at June 16, 2005 meeting with faith community co-sponsored by DHR and Emory Interfaith Coalition. (Enabling)

Collaborated with the Department of Juvenile Justice (DJJ) to conduct a pilot in Rome, Georgia for a coordinated system of care for youth upon release from DJJ facilities. (Infrastructure)

Increased knowledge about adolescence and positive youth development through education and professional development programs for adults (Kennesaw State University regional training in Developmental Assets for Youth. (Enabling)

Provided confidential family planning services to Georgia youth at 260 clinic sites. Services included abstinence education and counseling and preventing sexual coercion education.

(Enabling and Direct Health Care)

Formed DHP workgroup to address repeat teen pregnancy. Workgroup strategies include use of informatics strategic planning, alignment of resources with best practices initiatives and removal of unnecessary bureaucracy. (Infrastructure)

Improved access to healthcare through continued funding of 31 teen center (TC) programs in 18 districts. TC outreach workers are decreasing the number of uninsured/underinsured youth and families through implementation of Medicaid/PeachCare outreach programs and removal of unnecessary bureaucracy associated with referral. TC are engaging the broader community to assess community assets and needs; have active youth and parent advisory councils; and actively engage other youth serving organizations, the faith community, education partners, and other PH programs to expand preventive health services, health education, and youth development initiatives for at-risk youth. (Direct Health Care)

Implemented education and professional development programs focused on Developmental Assets for Youth in partnership with Kennesaw State University. (Enabling)

Developed and implemented uniform operating procedures and requirements manual for teen centers. (Infrastructure)

Continued to implement BART survey at all TC sites. (Enabling)

Collaborated with and supported efforts of local teen clinic Parent Advisory Committees to determine programs and activities offered at public health teen clinics. Supported efforts of teen clinic Parent Education Programs (PEP) to offer and publicize programs in the community to enable parents to be more effective communicators with their teens. (Enabling)

Collected and analyzed state teen pregnancy data. (Infrastructure)

Increased public awareness through newspaper articles in key state papers and television. (Enabling)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuing training, technical assistance and monitoring of contracts and Grant-in-Aid (GIA), both of which include deliverables that address community and parent education/collaboration, outreach, and youth development activities for teens to support				X
2. Collaborating with DCH to provide linkage with Medicaid and PeachCare for Kids for case management and receipt of medical services.				X
3. Collaborating with the Department of Juvenile Justice to provide services to youth Collaborating with DCH to provide linkage with Medicaid and PeachCare for Kids for case management and receipt of medical services upon release.				X
4. Operating family planning clinics for teens in health department and non-traditional sites (e.g., night clinic, vans, jails, DFACS offices.)	X			
5. Funding Southside Medical Hospital Project, working with adolescent males to encourage them to get involved in health				X

care.				
6. Providing abstinence and teen pregnancy information and contraceptive services in teen centers operating in each district.	X			
7. Participating in the development of Regional Comprehensive Youth Development Systems throughout Georgia.				X
8.				
9.				
10.				

b. Current Activities

Served 15,824 unduplicated teens between the ages of 15 and 17 in the Georgia Family Planning Program in calendar year 2008. An additional 19,009 teens between the ages of 18 and 19 were served as well as 2,225 teens under the age of 15. (Direct health care)

Continuing to fund 30 teen center programs in 27 counties, a Youth Development Coordinator for each of the 18 public health districts, and 7 Sexual Violence Prevention (RPE) programs located throughout Georgia. Teen center programs are operated through county health departments statewide and located in counties reporting high rates of high school dropouts, HIV/STDs, and/or teen pregnancy. Each program has established a Parent Advisory Committee to provide parents a meaningful way to participate in planning, decision-making, and opportunities for positive health promotion. The RPE programs provide education, training, materials and the operation of information hotlines the focus is on prevention programs for school age (elementary -- high school) and for young adults (college students). (Infrastructure)

Implemented 29,946 comprehensive health and youth development service plans, 4,355 youth-focused activities/events, 545 public awareness and community education events, 332 professional in-service training events, and 2,661 RPE educational sessions for 68,696 participants. Distributed 86,936 RPE informational units. (Enabling)

c. Plan for the Coming Year

Continue to provide family planning program services for teens aged 15 through 17.

Continue to fund teen center programs, district Youth Development Coordinators, and Sexual Violence Prevention programs.

Provide 1,077 youth-focused activities/events, 488 public awareness and community education events, and 810 professional in-service training events.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	13.5	39	40	15	17.2
Annual Indicator	19.6	19.4	19.8	17.1	23.4
Numerator	10636	9630	9188	8103	6929
Denominator	54186	49562	46506	47255	29553
Data Source					Georgia Oral Health Program
Check this box if you cannot report the					

numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	24	24	24	24	24

Notes - 2006

The 2005 original data report showed 19,353 sealant participants. Upon development of a new database with clean data, the totals for the years 2001-2005 dropped significantly. There were many double entries for data in the clinical and prevention records in the old database. The new design eliminates the opportunities for errors. The districts that were entering data incorrectly have received additional training on how to use the old db, until the new one can be implemented statewide.

a. Last Year's Accomplishments

Assisted districts with the development, implementation, and ongoing evaluation of their preventive oral health service programs. (Infrastructure)

Worked with schools throughout the state on dental health education and screening programs. (Enabling)

Contracted with Georgia Health Policy Center to provide reports on Medicaid/PeachCare CY 2005 data analysis and GOHP FY 2005 and 2006 programmatic data and time series reports 2000-2005 that document statewide access to oral health care. (Infrastructure)

Implemented GADS district projects and completed monitoring site visits. (Infrastructure)

In collaboration with DECAL, conducted the 2006 Head Start Oral Health Forum to develop a statewide strategic work plan to address the oral health needs of young, at risk children. (Infrastructure and Enabling)

Developed and shared the Georgia 3rd Grade Oral Health Survey Reports (GA3GOHS) and assisted reporting of obesity status measures collected in the survey. The survey was funded by Georgia Access to Dental Services (GADS) III/States Oral Health Collaborative Systems Grant. The survey measured access to dental care, disease status, and dental sealants on 1st permanent molar teeth and gathered measurements of height and weight (nutrition status). (Infrastructure)

Participated in the development of the 3300 Audit report, measuring appropriate use of School Screening Form 3300, in collaboration with School Health and Nutrition programs. (Infrastructure)

Developed collaborations with the Head Start program to increase access to care through partnerships with public health and measure disease status and access to care for young, at risk children. (Infrastructure)

Conducted monitoring and TA for Georgia Rural Water contract deliverable. Provided guidance to ensure compliance with contract. Assisted with training manual updates. (Infrastructure)

Conducted Georgia Dental Health Poster Contest for elementary school age children (grades K-5) promoting oral health awareness. (Enabling)

Served as member of the Association of State and Territorial Dental Directors, Committee on

School and Adolescent Oral Health and the Executive and Data/Surveillance Committees to provide national data on access to care for this population. (Infrastructure and Population-based)

Participated in state level implementation of Care Managed Organization management of the Medicaid/PeachCare programs. Provided ongoing TA to local level programs. (Infrastructure)

Acquired two new mobile dental trailers for the school based program. The program now has 11 trailers and two vans. (Infrastructure)

Conducted third grade oral health survey, completed survey reports, and shared the results with key partners and decision makers. (Infrastructure)

Produced an oral health resource CD for district dental staff, partners, and professionals to share Best Practices developed through GADS I grant projects and prevention education resources. (Enabling)

Provided dental sealants to children through public health school mobile based dental clinics and fixed dental facilities. (Direct Care)

Held statewide Head Start forum in May 2007 to share Best Practices initiated at 2006 statewide Oral Health Summit and continue strategic planning, including educating parents, staff and decision makers on importance of establishing a dental home. (Infrastructure)

Provided training to school nurses on oral disease prevention, use of fluoride varnish and on providing dental screenings and referrals. (Enabling)

Conducted Head Start oral health screening survey. (Infrastructure)

Completed the GADS I Integrated Systems Grant project period (June 2006). Sharing Best Practices with local programs and partner agencies. (Infrastructure)

Contracted with Georgia Health Policy Center for Medicaid/PeachCare claims analysis to measure access to care in CY2004 and 2005, CY 2000-2005 trend analysis, and public health program service analysis. (Infrastructure)

Developed a Georgia specific fluoride varnish training manual for providers, video clips of oral health care for young, at risk children and Head Start parents and staff. (Infrastructure)

Shared oral health resource CD for district dental staff, partners, and professionals to share Best Practices developed through GADS I grant projects and prevention education resources. (Enabling)

Provided dental sealants to 8,103 children in FY 2007 through public health school mobile based dental clinics and fixed dental facilities. (Direct Care)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuing to visit schools to conduct screenings on children, place sealants when needed and provide prevention services, education, and fluoride treatments.	X			
2. Continuing implementation of statewide surveys that measure oral health status, including project monitoring and evaluation through submitted reports.				X
3. Sharing Best Practices through quarterly Oral Health				X

Coordinators' meetings with dental public health providers throughout the state.				
4. Continuing to provide ongoing consultative support and technical assistance to the districts, including monitoring and evaluation.				X
5. Continuing efforts to adjust salaries for district dental oral health staff.				X
6. Continuing provision of technical assistance and monitoring to district mobile dental trailer program to provide dental services at elementary school sites (selected by high student participation in the free and reduced lunch program).				X
7. Continuing efforts to build and strengthen infrastructure through school-based/linked program expansion.				X
8. Continuing to train school and public health nurses on oral disease prevention and to provide oral screenings. Provision of training in application of fluoride varnish to the medical and dental professional communities. Provision of training in oral				X
9.				
10.				

b. Current Activities

Received Centers for Disease Control and Prevention State-Based Oral Disease Prevention Program grant. The five-year agreement provides funds for Oral Health to strengthen infrastructure and capacity to prevent oral disease and promote oral health, with a very strong emphasis on school-based/linked sealant programs. Oral Health is in the process of hiring a Dental Sealant and Oral Health Education Specialist that will plan, organize, and implement a comprehensive statewide school-based oral health education and dental sealant program. The specialist will develop the program based on burden of disease and best practices. Infrastructure)

In FY 2008, provided 6,929 children with dental sealants through the school-based and school-linked Oral Disease Prevention Program. In fixed clinic sites, 25,392 sealant procedures were performed. (Direct Health Care)

c. Plan for the Coming Year

Continue to place sealants on third grade children's permanent molars through the 44 county dental clinics and 14 Public Health mobile dental clinics located throughout Georgia.

Purchase two new mobile dental clinics to serve the Lawrenceville and Waycross Health Districts. These mobile clinics will allow Oral Health to expand dental sealant programs to more third grade children.

Continue implementation of CDC State-based Oral Disease Prevention Program Cooperative Agreement, including filling new positions, such as a new Georgia Oral Health Program dental sealant/water fluoridation position to oversee targeted school sealant and statewide community water fluoridation activities.

Develop plans to perform 3rd Grade Oral Health Survey to provide statewide assessment of the oral health status of elementary school children.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	5.4	4.2	4.2	3.4	4
Annual Indicator	4.6	3.5	3.5	4.2	3.6
Numerator	89	68	68	85	75
Denominator	1954254	1969278	1969278	2035969	2109362
Data Source					Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	3.5	3.4	3.2	3.1	3

Notes - 2006

Data for 2006 is not yet available and will be provided in the FY 2009 MCHBG.

a. Last Year's Accomplishments

Conducted regional trainings based on district level community needs assessments and resources. (Enabling)

Developed collaborative relationships between the Injury Prevention Section, Children's Medical Services, and health care providers to promote transportation of children with special medical needs. (Enabling)

Assisted (Injury Prevention Section) with 30 trainings for local child fatality review boards. Training encompassed motor vehicle safety issues and focused on preventability. (Enabling)

Collaborated with Injury Prevention Section to conduct training for Youth Development Coordinators. Trainings focused on strategies for prevention education activities for adolescents, including parenting teens. (Enabling)

Identified motor vehicle crashes to children under 14 as a prevention component of the middle childhood initiative. (Infrastructure)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Providing training, technical assistance and monitoring regarding activities related to child passenger safety activities.		X		X
2. Distributing child safety seats. Providing training, technical assistance and monitoring regarding activities related to child			X	

passenger safety activities.				
3. Providing education on child passenger safety.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Providing training, technical assistance, and monitoring regarding activities related to child passenger safety activities. (Infrastructure, Enabling)

Distributing child safety seats throughout Georgia to those in need. (Population-based)

Providing education to parents and other caregivers on child passenger safety and how to correctly install car seats. (Enabling)

c. Plan for the Coming Year

Continue providing training, technical assistance, and monitoring regarding activities related to child passenger safety activities.

Continue distributing child safety seats throughout Georgia to those in need.

Continue providing education to parents and other caregivers on child passenger safety and how to correctly install car seats.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			31	32	33
Annual Indicator		30.4	29.2	30	29.5
Numerator					
Denominator					
Data Source					NIS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	35	35	35	35	35

Notes - 2008

Data decrease may show a trend of increasing numbers of young mothers returning to the workforce earlier than in past years, for economic reasons . Also, lack of evidence-based

maternity care practices and huge increases in the percentage of cesarean deliveries both tend to decrease breastfeeding initiation and especially duration rates.

Notes - 2007

This is survey data, a demoninator and numerator would not be feasible.

Notes - 2006

The latest data available is from the 2005 National Immunization Survey.

a. Last Year's Accomplishments

Offered breastfeeding training and resources for all PCM/ORS training participants. All PCM/PRS clients are encouraged and assisted to breastfeed their infants. (Enabling)

Continued breastfeeding initiatives at all regional perinatal centers to promote breastfeeding for high-risk neonates. (Enabling)

Incorporated breastfeeding promotion strategies as a key component of "Overweight and Obesity in Georgia 2005" (released May 2005) and Georgia's State Plan for Nutrition and Physical Activity (Take Charge of Your Health, Georgia!) to prevent obesity and other chronic diseases. (Report released in June 2005.) (Infrastructure)

Breastfeeding awareness proclamation signed by Governor Perdue and news release issued to media, "Governor Perdue helps raise awareness about health benefits of breastfeeding." (Enabling)

Promoted the "Loving Support Makes Breastfeeding Work" campaign as the consistent breastfeeding message. (Enabling)

Providing support and orientation to the DHR workplace lactation room. (Enabling)

Worked with WIC Branch to create a breastfeeding duration reporting system. (Infrastructure)

Provided technical assistance for the WIC Breastfeeding Peer Counselor Program in nine sites. (Enabling)

Provided training and support on breastfeeding activities for internal and external partners. (Enabling)

Continued funding the WIC Breastfeeding Peer Counselor Program. (Infrastructure)

Awarded contract for development and implementation of the Educating Physicians in Their Community (EPIC) Breastfeeding Education Program. (Infrastructure)

Developed curriculum for Educating Physicians In their Communities (EPIC) breastfeeding program in collaboration with CDC, physicians, lactation consultants and the state breastfeeding coordinator, which focuses on the specific breastfeeding education needs of pediatricians, obstetricians and family practitioners.

Formed the Georgia Breastfeeding Coalition, with a membership of over 150 individuals. (Enabling)

Developed a state breastfeeding logic model, which encompasses the six CDC evidence-based breastfeeding interventions. (Infrastructure)

Employed a full-time state breastfeeding coordinator. (Infrastructure)

Provided technical assistance for the WIC Breastfeeding Peer Counselor Program in nine sites. (Enabling)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintaining breastfeeding coalitions and collaborative efforts at the state and district level.				X
2. Assisting districts in implementing breastfeeding education and support plans.				X
3. Continuing monitoring and surveillance of breastfeeding initiation and duration data.				X
4. Integrating breastfeeding promotion into relevant MCH, public health and community-based programs such as Children 1st, Regional Perinatal System, Perinatal Case Management (PCM), Georgia's Nutrition and Physical Activity Initiative to prevent obesity				X
5. Continuing to implement revised data collection system in WIC and monitoring new data on duration rates.				X
6. Distributing revised Peer Counselor Program Guidelines to district programs as standards of care and best practices.				X
7. Making site visits to district Peer Counselor Programs to offer technical assistance and conduct program evaluations.				X
8. Expanding outreach to Georgia businesses and corporations via "The Business Case for Breastfeeding" toolkit.				
9. Maintaining the Lactation Room at the state office building.		X		
10. Continuing contract for Peer Counselor training and Peer Counselor supervisor in-service training and education.				X

b. Current Activities

Began implementation of WIC Branch's revised data collection system to capture more accurate six-month breastfeeding duration rates. (Infrastructure)

Collaborated with Georgia Breastfeeding Coalition to implement "The Business Case for Breastfeeding," a federally created program that trains lactation specialists, including peer counselors, to provide outreach and technical assistance to small and large businesses that are interested in establishing a lactation support program for employees. Training continues across the state under the guidance of the original grant recipients. (Infrastructure, enabling)

Continuing maintenance of lactation room at DHR state office building for use by mothers and visitors. (Enabling)

Revised peer counselor program guidelines and created site visit review tool. (Infrastructure)

Provided 37 new and existing peer counselors in seven peer counselor programs across the state with customized training by an experienced contractor. (Enabling)

c. Plan for the Coming Year

Continue to educate mothers on the benefits of breastfeeding and provide support for breastfeeding complications.

Increase the role of the Breastfeeding Advisory Committee in setting the direction for statewide efforts to increase the percentage of infants who are breastfeeding at age six months. The committee has scheduled a two-day meeting in early summer at which time a work group will begin the process of creating a five-year strategic plan and revising the existing logic model. Emphasis will be placed on creating or strengthening public-private partnerships through regional breast feeding coalitions and the Georgia Breastfeeding Coalition.

Evaluate the Loving Support™ Breastfeeding Peer Counselor Program by conducting site visits to the existing seven Peer Counselor programs. Technical support will emphasize peer counselor training and supervision and best practices.

Work more closely with the Nutrition and Physical Activity Grant Demonstration Project in further developing community partnerships to effect changes in maternity care practices that impact breastfeeding and enhance support for breastfeeding mothers.

Integrate breastfeeding education, promotion, and support across all relevant program areas in public health.

Use CDC/HRSA "The Business Case for Breastfeeding" toolkit to encourage businesses to establish or enhance lactation support programs for employees.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	95	95	97	98.6	98.7
Annual Indicator	97.5	95.6	98.5	94.5	99.0
Numerator	132694	136479	140201	140201	127191
Denominator	136123	142750	142322	148403	128532
Data Source					Newborn Hearing Program Data
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	99.1	99.2	99.3	99.4	99.5

Notes - 2007

The denominator for 2006 has been updated based on finalized vital statistics for the number of births occurring in Georgia hospitals. The denominator for 2007 is based on hospital reporting and will be updated in MCHBG FY2009 with vital statistics.

Notes - 2006

The denominator for 2005 has been updated based on finalized vital statistics for the number of births occurring in Georgia hospitals. The denominator for 2006 is based on hospital reporting and will be updated in MCHBG FY2008 with vital statistics.

a. Last Year's Accomplishments

Screened 98 percent of all newborns prior to discharge from birthing hospitals, with a statewide referral rate of 4 percent. (Population-Based)

Effective January 1, 2005, implemented new hospital incentive funds requirement to increase screening rates to 95%, in an effort to ensure that all babies receive a hearing screen prior to hospital discharge. (Population-Based)

Provided funds to 11 health districts to purchase screening equipment to increase follow-up screening rate for infants not passing the initial hospital screen. (Infrastructure)

Provided technical assistance to hospitals, district staff, and providers on reporting requirements and follow-up for UNHS. (Infrastructure)

Conducted annual hospital and audiology survey to assess provider needs in UNHS process. (Infrastructure)

Implemented Access database in seven pilot districts to improve tracking and surveillance of infants referred through UNHS. (Infrastructure)

Continued to collaborate with MCH Epidemiologist in development of a statewide web-based system to track and monitor infants and children through UNHS for surveillance and quality assurance. (Infrastructure)

Developed final version of UNHS Resource Guide to inform providers and public of the importance and availability of newborn hearing screening and offer resources for follow-up and intervention throughout the state. (Population-Based)

Completed application for three-year HRSA grant to provide training on the use of the web-based tracking and surveillance system and evaluate its effectiveness. (Infrastructure)

Provided technical assistance and training to hospitals, district staff and providers on reporting requirements and follow up guidelines for UNHSI. (Enabling)

Reviewed and assessed quarterly data submitted by hospitals and districts on initial hearing screening and tracking and monitoring of performance. (Infrastructure)

Conducted annual hospital and audiology survey to assess provider needs in UNHSI process. (Infrastructure)

Continued to collaborate with MCH Epidemiologist in the development of a statewide web-based system to track and monitor infants and children through UNHSI for surveillance and quality assurance. (Infrastructure)

Provided training and educational opportunities for public health staff, hospitals, audiologists, physicians, and parents to increase awareness and improve knowledge of the early detection of hearing loss. (Enabling)

Received three-year grant from HRSA to implement strategies aimed at reducing newborns with an initial failed hearing screen that are lost to follow-up. The objectives of the grant are to: 1) establish a state workgroup to guide the development of the UNHSI follow-up system; 2) develop,

test, and implement standardized scripts, templates, and protocols statewide; and 3) provide professional training and education to public and private providers on use of SENDSS to report to UNHSI. (Infrastructure)

Piloted SENDSS UNHSI module in one health district. The module will be used by health districts to perform failed hearing screen follow-up. Activities are underway to operationalize the UNHSI module in all 18 health districts. (Infrastructure)

Developed user communication plan, user manual, reports, and parent and provider notification letters. (Infrastructure)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuing to analyze quarterly hospital hearing screening data to identify hospitals with unsatisfactory screening and referral performance.				X
2. Continuing to promote UNHSI.			X	
3. Providing training and technical assistance to hospitals screening newborns.				X
4. Developing data system to link newborn hearing screening information with electronic birth certificate.				X
5. Providing technical assistance to Children 1st in health districts to link with children identified through screening reports from hospitals.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Screened 99% of all newborns prior to discharge from birthing hospitals, with a statewide referral rate of 3%. (Population-based)

Filled UNSHI Coordinator position with a pediatric audiologist. (Infrastructure)

Awarded a contract to a second pediatric audiologist to assist with SENDSS Newborn and other programmatic development activities. (Infrastructure)

Updated list of pediatric audiologists in Georgia. (Infrastructure)

Developed an email distribution list to facilitate communication regarding UNHSI. (Infrastructure)

c. Plan for the Coming Year

Implement HRSA grant which focuses on reducing the lost to follow-up rate.

Implement strategies to improve the current UNHSI follow-up and tracking system.

Update UNHSI Program guidelines.

Update UNHSI website.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	11	13	12	11.7	13.2
Annual Indicator	12.5	11.8	11.8	13.3	11.8
Numerator	291742	294084	294084	339526	312592
Denominator	2341025	2497888	2497888	2562366	2644818
Data Source					GSU Sources of Health Insurance Coverage
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	11.7	11.6	11.5	11.4	11.3

Notes - 2007

Data is from a report produced by Georgia State University, Sources of Health Insurance Coverage, 2006, that is compiled from data from the Annual Social Economic Supplement, Current Population Survey, U.S. Census Bureau.

Notes - 2006

CY 2006 data is not yet available and will be reported in the FY 2009 BG.

a. Last Year's Accomplishments

Served on Healthy Mothers, Healthy Babies Coalition of Georgia (HMHB) advisory group to provide information about health services and available health insurance for Georgia's children. (Enabling)

Served on the Covering Kids and Families program to address the health needs of the state's uninsured and underinsured population. (Enabling)

Continued to assist families during the Children 1st family assessment process in completing forms for enrollment into Medicaid and PeachCare. (Enabling)

Conducted regional trainings focused on uninsured adolescents (stated deliverable for three GIAs funded by AHYD). (Enabling)

Scheduled training/technical assistance teleconferences with individual district teams responsible for outreach to uninsured adolescents. (Infrastructure)

Implemented use by the Well Child Team of revised outreach monitoring forms that actively track non Georgia Better Health Care members to ensure they get well child services and follow up care. (Infrastructure)

Collaborated with other state agencies and partners to assure implementation of a client referral and tracking system for teen centers to assure access for uninsured youth. (Infrastructure)

Continuing to assist enrolled CMS in obtaining health insurance. 15% (1,273) of enrolled CMS clients (primarily undocumented clients and/or youth ages 19-21 years of age) do not have insurance.

Continued to work on integrating services for CSHCNs. (Infrastructure)

Continued to facilitate client and family use of all available service systems. (Enabling)

Local CMS Staff in rural areas of the state conducted clinics in specialty areas for CSCHN to insure access in communities lacking such services. (Direct Health Care)

Worked (AHYD) with BCW and ICH Health Program Coordinator to assess training and technical assistance and resource sharing needs to assure collaboration between funded activities and among district MCH activities. (Infrastructure)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Providing training, technical assistance and monitoring of Grant-in-Aid (GIA) annex deliverables related to PeachCare and Medicaid outreach, referral and administrative case management.				X
2. Continuing collaborations with DFACS and DCH to plan and coordinate "Cover the Uninsured Week" activities for teens throughout Georgia.				X
3. Providing training, technical assistance and monitoring of GIA annex deliverables related to assuring a medical home for all children and adolescents and their families lacking insurance.				X
4. Continuing to assist families, during the Children 1st Family Assessment, in completing necessary forms for enrollment in Medicaid or PeachCare for Kids.		X		
5. Sharing Medicaid and PeachCare for Kids information at community health fairs, training, exhibits, etc.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Continuing to assess health care coverage of all clients referred to CMS programs. (Enabling)

Continuing to assist CMS clients with applying for insurance based on eligibility. Of 8,491 clients in CMS, approximately 63% have Medicaid, 8% have PeachCare, 12% private insurance, 2% Tri Care, and 16% CMS only. Georgia's CSHCN without insurance at some point in the past year was 10.4% compared to 8.8% for the nation as a whole and 1% for non-CSHCN, according to the National Survey for CSHCN 2006-2007. Insured Georgia CSHCN whose insurance is inadequate is reported at 32.6% compared to 33.1% nationally and 26.3% for non-CSHCN in the nation. (Enabling)

Continuing to collaborate with other CSN programs to ensure that each child receives a health care need assessment. (Infrastructure)

c. Plan for the Coming Year

Continue to assist clients with insurance applications based on client eligibility.

Assess and evaluate other reduced cost health care programs available in Georgia.

Assist families in finding employment with reduced cost health insurance via referrals to employment programs and care coordination.

Encourage health promotion through care coordination that works to reduce a child's need for medical management.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			8.3	15	29
Annual Indicator		28.0	28.0	30.9	30.9
Numerator		27999	27999	31225	31225
Denominator		99998	99998	101052	101052
Data Source					WIC
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	2010	2011	2012	2013
Annual Performance Objective	28	27	26	25	25

Notes - 2008

2008 Data currently unavailable & will be reported for 2011

Notes - 2007

Data is an average of 2005 data available. CY 2006 data is not yet available.

Notes - 2006

Data is for CY 2005. CY 2006 is not yet available and will be provided in the FY 2009 MCHBG.

a. Last Year's Accomplishments

Provided individual counseling to WIC participants on a variety of nutrition topics addressing healthy weight (e.g., healthy eating, stress-free feeding, physical activity). (Enabling)

Provided group nutrition education to WIC participants through healthy eating and physical activity programs such as Magic Bag program, FUN Club, and healthy cooking demonstrations. (Enabling)

Provided training to programmatic and other health services staff on addressing child nutrition and pediatric overweight. (Enabling)

Using a public health approach, provided training to 80 WIC staff on addressing childhood overweight. (Enabling)

Through Health Check reviews, monitoring for BMI carried out by Well Child Team. Children measuring at or above the 85th percentile require parent counseling, treatment and/or further evaluation. (Population-based)

Using CDC growth charts, continued to evaluate BMI as required by HealthCheck. (Population-based)

Began development in Waycross Health District of the FIT WIC program, adapted from Virginia model, which focuses on healthy eating and physical activity. (Infrastructure)

Required that each health district include at least one objective in their work plans that addressed childhood overweight in WIC program activities. (Infrastructure)

Worked with state-level WIC, Evaluation, and/or IT staff to develop an integrated BMI surveillance system for each of the existing WIC front-end user software systems. This will allow facilitate statewide collection of BMI data elements for WIC at risk and targeted population groups. Data will be used to direct specific program resources and implement targeted activities in health districts with higher prevalence of increased BMI values. (i.e., Fit WIC) (Infrastructure)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Providing individual counseling to WIC participants on a variety of nutrition topics addressing healthy weight (i.e., healthy eating, stress-free feeding, physical activity).			X	
2. Providing group nutrition education to WIC participants through healthy eating and physical activity programs (i.e., Magic Bag program, FUN Club, healthy cooking demonstrations).			X	
3. Providing training to WIC staff on addressing childhood overweight using a public health approach.				X
4. Collaborating with DCH to provide Lunch and Learn sessions with private providers and share information about services available to Medicaid and PeachCare for Kids eligible children.				X
5. Providing quality assurance site visits to the private sector to assure Health Check services to children are provided appropriately.				X
6. Collaborating with DCH, DFCS, GA AAP to ensure children				X

who are in state custody foster care receive appropriate health services through the Medicaid program.				
7. Continuing across team collaboration to assure children who are eligible for Medicaid and PeachCare receive available services, i.e., CMS case management, HRIFU, BCW, Children 1st, AHYD, PRS.				X
8. Monitoring by chart review during Health Check site visits if further evaluation or parent counseling is required.				X
9.				
10.				

b. Current Activities

Continuing to provide support to health districts, OBO programmatic and other health services staff, WIC participants and WIC staff, including individual and group counseling to WIC participants on a variety of nutritional topics, training for WIC staff, training to OBO staff, and BMI monitoring through Health Check reviews. (Enabling)

Updated WIC Food Packages to offer more healthy (particularly lower in fat and sugar) food choices. (Enabling)

Continuing to facilitate integration of client-centered nutrition counseling techniques, which have been proven to be more effective in obesity interventions. (Enabling)

Assisting with promotion and establishment of Fit WIC program. (Infrastructure)

Instituting electronic data collection fields related to nutrition and physical activity practices for forthcoming dissemination of updated nutrition assessment forms. This will facilitate provision of obesity intervention-related targeted WIC programming. Infrastructure)

c. Plan for the Coming Year

Continue implementation of WIC Food Package healthy choices.

Continue to facilitate integration of client-centered nutrition counseling techniques within the WIC program statewide.

Implement nutrition and physical activity practice electronic data collection fields on WIC nutrition assessment forms. (Work is depending on WIC Systems Unit.)

Continue implementation of Fit WIC program infrastructure/capacity-building activities to ensure execution of obesity prevention/intervention program strategies.

Continue to provide nutrition support to health districts, OBO programmatic and other health services staff, WIC participants and WIC staff, i.e., staff training, individual and group counseling for WIC participants, BMI monitoring through Health Check reviews.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
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Annual Performance Objective			8.2	10.2	10.1
Annual Indicator		8.4	8.4	10.3	9.3
Numerator		10783	10783	13818	13802
Denominator		128078	128078	134114	148403
Data Source					GA PRAMS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	9.2	9.1	9	9	9

Notes - 2006

Data is final for CY 2005. CY 2006 data is not yet available.

a. Last Year's Accomplishments

Promoted tobacco cessation by providing educational materials to physicians and nurses.
(Enabling)

Promoted the QuitLine by providing educational materials to physicians and nurses. (Enabling)

Finalized Maternal Substance Abuse position paper, which serves as a resource for state and communities in planning and developing policies. (Infrastructure)

Purchased and distributed educational literature in English and Spanish to community providers.
(Enabling)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conducting statewide perinatal center training in 13 of 18 public health districts.				X
2. Continuing Council on Maternal and Infant Health participation in regional perinatal center activities.				X
3. Providing preconception health counseling to family planning clients.			X	
4. Continuing to provide perinatal case management training.				X
5. Continuing to promote interconceptional periods of at least 1 ½ to 2 years.			X	
6. Continuing work with Tobacco Control Program on tobacco use prevention and cessation for maternal clients.				X
7. Working with regional tertiary hospitals to improve communication in the community.				X
8. Collaborating with March of Dimes for premature clients, working with community and private providers.				X
9. Continuing to collaborate with WIC on activities to improve communication with clients receiving services from Women's Health and WIC.				X

10.				
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b. Current Activities

Promoting preconception health screening. (Enabling)

Providing education and educational materials in English and Spanish to community partners.
(Enabling)

Referring pregnant women who smoke to Georgia Tobacco Quit Line. (Enabling)

c. Plan for the Coming Year

Continue preconception health promotion.

Continue screening pregnant women.

Continue to provide education and educational materials in English and Spanish.

Continue to refer pregnant women who smoke to Georgia Tobacco Quit Line, Georgia Smoking Cessation Program, or other community resources.

Collaborate with the Georgia Quitline Program on case management services for pregnant women.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	7.8	7.7	7.7	4.5	5.4
Annual Indicator	8.0	4.6	4.6	5.5	4.6
Numerator	50	30	30	37	31
Denominator	625991	646904	646904	677128	679005
Data Source					Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	4.5	4.4	4.3	4.2	4.1

Notes - 2006

CY 2006 data is not yet available and will be provided in the FY 2009 BG.

a. Last Year's Accomplishments

Conducted Teen Surveillance through implementation of the BART Survey in five pilot districts.
(Infrastructure)

Developed and distributed the second edition of private sector mental health service provider directory for statewide use. (Infrastructure, Enabling)

Provided education to state and local staff to increase awareness of suicide prevention strategies and prevalence of suicide among youth. (Enabling)

Collaborated with state Suicide Advisory Committee on suicide awareness initiatives. (Infrastructure)

Continued to monitor GIA deliverable activities related to adolescent mental health and wellness. (Infrastructure)

Expanded Teen Center deliverables to include mandated Bright Futures assessment. (Infrastructure)

Provided education to state and local staff to increase awareness of suicide prevention strategies and prevalence of suicide among youth. (Enabling)

Continued AHYD work with FHB Mental Health Program Specialist and School Health Coordinator to assess training and technical assistance needs, identify information and resource sharing opportunities, and to assure collaboration with other state agencies and community partners regarding best practice research and national and state priorities and youth suicide trends. (Enabling)

Continued to conduct Teen Surveillance through BART survey expansion into all districts. (Infrastructure)

Continued development of a statewide data system and performance indicators for AHYD programs. (Infrastructure)

Drafted first edition of the Teen Center Requirements and Procedures Manual with edits and input from medical consultant. (Infrastructure)

Provided T/TA to assure continued implementation of Bright Futures Assessment through 31 Teen Centers. (Infrastructure)

Disseminated Teen Center Requirements and Procedures Manual. (Infrastructure)

Provided TA to assure continued implementation of Bright Futures Assessment through 31 Teen Centers. (Infrastructure)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Providing training, technical assistance and monitoring of district activities and progress related to suicide prevention plans and objectives.				X
2. Continuing collaborations with the Department of Behavioral Health, Office of Injury Prevention, Aging and other agency staff in the development of a state suicide prevention plan that includes staff development and distribution of statewide listings				X
3. Continuing development of MCH referral, intake, and assessment processes to identify adolescents “at risk” and to				X

assure timely receipt of appropriate mental health resources.				
4. Continuing to develop outcome and contract requirements, performance expectations/indicators, and policies and procedures for contracts and Grant-in-Aid annexes related to adolescent mental health and wellness.				X
5. Continuing funding and implementation of youth development programs and activities that provide adult supervised activities, caring adult mentors, and peer educators for targeted youth.				X
6. Providing training and technical assistance to the Georgia Association of School Nurses and other school health professionals to provide training and technical assistance related to suicide prevention.				X
7. Continuing to provide information to CMS staff on identification and referral of at-risk clients.				X
8.				
9.				
10.				

b. Current Activities

Continued dissemination of statewide directory of mental health resources. (Infrastructure)

Continued to monitor GIA deliverables related to adolescent mental health and wellness. (Infrastructure)

Provided education to state and local staff to increase awareness of suicide prevention strategies and prevalence of suicide among youth. (Enabling)

Continued AHYD work with FHB Mental Health Program Specialist and School Health Coordinator to assess training and technical assistance needs, identify information and resource sharing opportunities, and to assure collaboration with other state agencies and community partners regarding best practice research and national and state priorities and youth suicide trends. (Enabling)

Collaborated with Injury Prevention on suicide initiatives. (Infrastructure)

Continued to collaborate with the state Suicide Advisory Committee on suicide awareness initiatives. (Infrastructure)

c. Plan for the Coming Year

Continue to collaborate with Injury Prevention on suicide initiatives.

Continue to collaborate with the state Suicide Advisory Committee on suicide awareness initiatives.

Continue to provide education to state and local staff to increase awareness of suicide prevention strategies and prevalence of suicide among youth.

Continue to conduct surveillance through BART survey implementation.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	75.5	76	76.5	77	77.5
Annual Indicator	74.2	74.9	74.9	73.3	73.1
Numerator	1873	1920	1920	1966	1931
Denominator	2524	2563	2563	2682	2641
Data Source					Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	70	70.5	71	71.5	72

Notes - 2008

This is a valid percent - while there is data for weight for all deliveries, there is not data for the facility level for all deliveries. Those births where facility level was unknown were excluded.

Notes - 2006

CY 2006 data is not yet available and will be provided with the FY 2009 BG.

a. Last Year's Accomplishments

Continued to provide high-risk maternal care to Georgia residents through the Regional Perinatal System. Of the total births that occur in Georgia annually, approximately 2,500 are very low birth weight babies; 76% of these babies are born at risk-appropriate perinatal hospitals in Georgia each year. (Direct Medical Care)

Continued to provide PMC training participants with Regional Perinatal System information to educate providers and consumers about the availability and benefits of these services. (Enabling)

Continued to provide education to basic and specialty hospitals on management of high-risk pregnancies and the prevention of preterm delivery. (Enabling)

Conducted bench peer review to evaluate the quality of care provided to high-risk maternal and neonatal patients in the Regional Perinatal Centers. (Infrastructure)

Continued outreach education to staff in community perinatal facilities on management of high-risk maternal and neonatal patients. (Enabling)

Continued outreach education to emergency room staff at non-perinatal facilities on emergency deliveries and stabilization of newborns. (Enabling)

Reviewed first draft of updated core requirements. (Infrastructure)

Completed and disseminated updated copy of Core Requirements and Guidelines for Designated Regional Perinatal Centers. (Infrastructure)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conducting annual performance audits at each regional center.				X
2. Working on outreach education plans at all regional perinatal centers.				X
3. Focusing perinatal case management (PCM) training on pre-term delivery prevention.				X
4. Continuing to work with the OB/GYN Society on increasing the number of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				X
5. Conducting bi-annual regional perinatal center clinical peer reviews.				X
6. Referring all high-risk Babies Born Healthy program participants to regional perinatal centers.			X	
7.				
8.				
9.				
10.				

b. Current Activities

Continuing to promote preconception health. (Enabling)

Encouraging screening, early identification, and management of risk factors in first trimester of pregnancy or as appropriate. (Enabling)

Encouraging referral of high-risk patients to tertiary care facilities. (Enabling)

Supporting transfer of high-risk neonates to risk-appropriate care facilities through Maternal and Infant contracts. (Infrastructure)

c. Plan for the Coming Year

Continue to promote preconception health.

Promote identification and management of risk factors in first trimester or as indicated.

Provide education in English and Spanish.

Continue to fund Regional Perinatal Centers to provide care for low income high-risk patients.

Update the Georgia Perinatal Guidelines, which set the standards for perinatal care.

Update the Core Requirements, which set the standards and guidelines for care in the Designated Regional Perinatal Centers.

Continue annual Regional Perinatal Center site reviews for correction of any identified deficiencies.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	86	86.3	86.5	86.8	87
Annual Indicator	81.9	81.2	81.2	79.2	79.2
Numerator	113503	114459	114459	117491	117491
Denominator	138561	140903	140903	148403	148403
Data Source					Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	2010	2011	2012	2013
Annual Performance Objective	64.5	65	65.5	66	66.2

Notes - 2008

The following measures will not be available for year 2008 due to a very high amount of missing data (>20%) or simply because they are no longer collected on the revised birth certificate:

- * Late or No Prenatal Care,
- * Kotelchuck Index,
- * Tobacco Use,
- * Alcohol Use.

For this reason, NPM 18 is reported the same as last year.

Notes - 2006

CY 2006 data is not yet available and will be provided in the FY2009 MCHBG.

a. Last Year's Accomplishments

Through partnership with Georgia Chapter of AAP, educated physicians across state on MCH and WIC issues. (Infrastructure)

Encouraged women seen in Family Planning clinics to seek prenatal care as early as possible after they know they are pregnant. (Enabling)

Utilized Resource Mothers to identify women in their first trimester care and to link them to prenatal care and other needed services. (Enabling)

Continued to encourage early entry into the WIC Program. (Enabling)

Continued to address through case management outreach. (Direct Medical Care)

Continued to recruit women through distribution of home pregnancy tests through the Resource Mothers program. (Direct Medical Care)

Continued to refer all PMC clients for entry into prenatal care and conduct follow up to ensure

clients are keeping their appointments. (Population-Based)

Received additional funding for Babies Born Healthy program for FY 2007. (Infrastructure)

Placed Preconceptional Health information on web and disseminated information to stakeholders and physician groups. (Enabling)

Partnered WIC local agencies with other community health providers and agencies to increase the number of early referrals made of prenatal women in their first trimester. (Enabling)

Provided counseling and referral of women in the family planning program who have positive pregnancy tests. (Enabling)

Received additional FY 2007 supplemental state funding for Babies Born Healthy Program. (Infrastructure)

Implemented contract with the Association of Family Practitioners (AFP) to increase physician knowledge and attitudes about preconception health. (Infrastructure)

Collaborated with Emory University to submit proposal to develop a reproductive planning tool for use in primary care settings. (Infrastructure)

Held symposium on Improving Birth Outcomes with approximately 150 participants. (Enabling)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuing to provide referrals to private OB providers, WIC and Medicaid for all clients enrolled in PCM.			X	
2. Providing Family Planning staff with opportunities to attend PCM training to learn about the importance of early entry into prenatal care.				X
3. Enrolling uninsured/underinsured, low-income pregnant women ineligible for Medicaid in Babies Born Healthy program.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Continuing to provide care to uninsured low income women through the Babies Born Healthy program. (Direct care)

Promoting bilingual patient education. (Enabling)

In collaboration with DCH and CMOs, developed and implemented a rapid process improvement pilot project in DeKalb County to improve the enrollment process of pregnant into first trimester care.

c. Plan for the Coming Year

Promote initiation of prenatal care in first trimester.

Evaluate the rapid process improvement pilot project implemented in DeKalb County. Implement statewide if evaluation results are positive.

Support provide education on best practices and standards of care.

Promote patient education in English and Spanish.

Seek increased funding for Babies Born Healthy program.

D. State Performance Measures

State Performance Measure 1: *Percentage of very low birth weight babies enrolled in High Risk Infant Follow-Up (HRIFU)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			21	23	25
Annual Indicator		18.5	23.3	16.7	15.6
Numerator		356	448	341	299
Denominator		1920	1920	2042	1920
Data Source					Vital Records
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	27	29	30	30	30

Notes - 2007

The numerator is from FY2005 data and the denominator is from 2004 infant birth-death linked data. The denominator is all VLBW births minus VLBW births that died within the first week of life.

Notes - 2006

The numerator is from FY2005 data and the denominator is from 2003 infant birth-death linked data. The denominator is all VLBW births minus VLBW births that died within the first week of life

a. Last Year's Accomplishments

Developed perinatal logic model to strengthen state's perinatal system. (Infrastructure)

Conducted outreach activities at local level, including presentations to community groups. (Enabling)

Placed HRIFU link on GA AAP web site. (Infrastructure)

Worked with Medicaid Managed Care (Care Management Organizations) to develop processes for FY 2006 statewide implementation. (Infrastructure)

Monitored impact of CMOs on enrollment and services for families with high risk infants. (Infrastructure)

Merged HRIFU deliverables and Key Performance Indicator into Birth to Five Grant-In Aid.

(Infrastructure)

Developed and implemented a "state of the HRIFU program" survey. Results were compiled and will be used to inform future planning activities. (Infrastructure)

Identified need for a planning committee to address survey report findings. (Infrastructure)

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implementing Child Find activities in every health district.			X	
2. Working with Care Management Organizations (CMOs) in process of transitioning infants on Medicaid and PeachCare for Kids into CMOs.			X	
3. Making presentations and exhibits on CYSN programs and activities at workshops, conferences, and meetings held throughout the state		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Continuing to monitor the impact of CMOs on enrollment and services for families with high risk infants. Identified CMO HRIFU reimbursement challenges include: 1) CMO reimbursement rates are low; 2) one CMO does not reimburse HRIFU for any home visits; and 3) the other two CMOs reimburse only for initial visit and any needed follow-up visits are not covered. (Infrastructure)

Developed and implemented a "state of the HRIFU program" survey. Results were compiled and will be used to inform future planning activities. (Infrastructure)

Identified need for a planning committee to address survey report findings. (Infrastructure)

c. Plan for the Coming Year

Establish a planning committee to develop plans to investigate the merger of HRIFU into the Children 1st or CMS program.

Increase enrollment of high risk infants in all CYSN programs.

Identify strategies to improve systems serving high risk infants.

Identify resources that can be leveraged to provide services to high risk infant populations.

State Performance Measure 2: *Percentage of high school students who participated in physical activity for at least 20 minutes on 3 or more of the past 7 days*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			65	66	67
Annual Indicator		61	61	61	43.8
Numerator					
Denominator					
Data Source					YBRS
Is the Data Provisional or Final?				Provisional	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	68	69	70	71	71

Notes - 2008

A numerator and denominator is not available for this percentages. Source: OASIS

Notes - 2007

Data is from the GA School Health Survey (YRBS). The survey is conducted every other year and the latest data available is for 2005. The data does not include numerator and denominator.

Notes - 2006

Data is from the GA School Health Survey (YRBS). The survey is conducted every other year and the latest data available is for 2005. The data does not include numerator and denominator.

a. Last Year's Accomplishments

Completed design of Fulton County nutrition and physical activity pilot initiative for African American teens and hired part-time project coordinator. (Infrastructure)

Resolution for healthy vending and concession stand choices in Georgia parks successfully passed by the Georgia Recreation and Park Association. (Enabling)

Collaborated with internal and external partners and stakeholders in addressing current educational requirements for physical activity. Completed DHR/DPH impact statement for proposed legislation. (Infrastructure)

Provided training, via videoconference, on the School Health Index. (Enabling)

Advocacy partners coordinated the submission of Senate Bill 272 (physical education in schools). Bill did not pass but raised awareness of the importance of PE and physical activity for children. (Enabling)

Partnered with Georgia After School Alliance to ensure the integration and importance of nutrition and physical activity in out-of-school/after school programs. (Enabling)

Partnered with TANF to integrate physical activity into Boys and Girls Club activities. (Enabling)

Assessed current quality and amount of physical education required in schools K-12 through School Health Profiles Survey (PROFILES). Disseminated survey to 400 schools. (Infrastructure)

Developed and disseminated 2006 Physical Activity Report and fact sheets to educate media, legislature, and partners. Infrastructure)

Released report on overweight in Georgia's 3rd grade children. (Infrastructure)

Implemented Nutrition and Physical Activity Grant-In-Aid. Waycross and Augusta partnered with area schools; provided mini-grants to schools to support increased physical activity, healthy food choices, and worksite wellness projects; provided schools with TA; and participated in local school wellness policy training. (Enabling)

Through AHYD, worked with CDC Obesity Project Coordinator, Nutrition, and School Health Coordinator to assess training and TA needs, share resources and information, and assure AHYD collaboration with other state agencies, DHR funded initiatives, and community partners regarding best practice research and national/state priorities and trends. (Enabling)

Continued Teen Surveillance through implementation of the BART Survey with 5 pilot districts. (Infrastructure)

Implemented and evaluated Fulton County nutrition and physical activity pilot initiative for African-American tweens. (Enabling)

Partnered with local schools to adopt Georgia Recreation and Parks Association (GRPA) resolution as policy. (Enabling)

Developed a position paper on the status of nutrition and physical activity in Georgia after-school program. (Infrastructure)

Developed and published PROFILES results. (Infrastructure)

Disseminated Physical Activity Report. Preparing and disseminating Walk to School Report (Infrastructure)

Worked with CDC Obesity Project Coordinator, Nutrition, and School Health Coordinator to assess training and technical assistance needs, share resources and information, and assure AHYD collaboration with other state agencies, DHR funded initiatives, and community partners regarding best practice research and national/state priorities and trends. (Enabling)

Through development and dissemination of new electronic newsletter, The Georgia Flavor, to partners (including Department of Education), provided education on and supported consideration of Senate Bill 506 which emphasized the importance of Georgia schools adhering to current physical education requirements. (Bill did not pass.) (Infrastructure)

Executed health promotion Grant-in-Aid (GIA) annexes in Waycross and Augusta, Georgia. As part of health promotion programs, school-aged children in at-risk geographic areas were taught the importance of regular physical activity. Opportunities were also identified for active engagement of this population group at specific events. (Infrastructure)

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Partnering with the Obesity team (via steering committees), which continues to educate local parks about adoption of Georgia Recreation and Park Association resolution as a policy.				X
2. Providing and tracking technical assistance to local school districts on developing local wellness policies through Grant-in-				X

Aid #154 annexes funded personnel and partnering with the Obesity team.				
3. Providing technical assistance to Nutrition and Physical Activity grantees on implementing and evaluating nutrition and physical activity initiatives.				X
4. Disseminating results of PROFILES.				X
5. Disseminating Physical Activity Report.				X
6. Disseminating Walk to School Report.				X
7. Monitoring, evaluating and providing feedback to Waycross and Augusta Nutrition and Physical Activity projects.				X
8.				
9.				
10.				

b. Current Activities

Continuing to dissemination Nutrition Unit electronic newsletter to provide service providers of children with information on the importance of partnering with the Unit to influence school-aged children to become more physically active. (Enabling)

Assisted State of Georgia Obesity Team and external partners in education efforts to support passage of HB-229, the Student Health and Physical Education (S.H.A.P.E.) Act. Bill passed during 2009 Georgia Legislative Session. (Infrastructure)

c. Plan for the Coming Year

Continue dissemination of Nutrition Unit electronic newsletter to provide service providers of children with information on the importance of partnering with the Unit to influence school-aged children to become more physically active.

Assist State of Georgia Obesity and external partners (e.g., Department of Education) with forthcoming plans to collect aggregate data pertaining to BMI and adherence to physical activity standards outlined in the S.H.A.P.E. Act.

Continue to steer Grant-in-Aid #154 Annexes toward building additional relationships with Georgia school systems' Wellness Policy Committees within their regions to support funded personnel's promotion of adherence to recently passed HB 229.

State Performance Measure 3: *Rate of hospitalizations due to unintentional injuries among children ages one through age four.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			174	173	173
Annual Indicator	174.8	191.0	191.0	201.1	140.1
Numerator	942	1050	1050	1119	819
Denominator	539005	549882	549882	556502	584503
Data Source					Vital

					Records
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	172	172	171	171	170

Notes - 2006

2006 Data is not yet available and will be provided in the FY 2009MCHBG.

a. Last Year's Accomplishments

Created logic model and work plan. (Infrastructure)

Created contract to target three leading causes of unintentional injuries among young children (motor vehicle accidents, SIDS, homicide/child abuse). (Infrastructure)

Developed nurse home visiting model that educates families about safety issues and assess home environment for safety concerns. (Infrastructure)

Worked on adoption of Bright Futures throughout DPH programs and in the private sector, which contributes to parent health and safety education. (Infrastructure)

Partnered with the Injury Section and Safe Kids to distribute infant safety seats. Support is provided to approximately 70 local health department child safety seat distribution programs through an incentive matching program that provides additional equipment. The program is specific to children ages 1 to 4 at-risk because of poverty level.
(Enabling)

Continued to support more than 30 Fire Safety Coalitions to provide additional smoke detectors, supplementing the program's reach to more Georgia homes with at-risk occupants such as young children. (Enabling)

Disseminated safety information to internal and external partners. (Enabling)

Along with Injury Prevention Section, provided resources and MCH Epi support for Child Fatality report that lists extensive prevention strategies by developmental age. (Enabling)

Provided support to the Injury Prevention section in the distribution of car seats and smoke detectors to families throughout the state. (Enabling)

Developed and implemented the Crib Matching Program to provide cribs and training to families at highest risk for SIDS and other infant related deaths. (Enabling)

Developed Georgia Childhood Injury Prevention Plan draft in collaboration with Office of Child Fatality Review. (Infrastructure)

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Providing training, technical assistance, and monitoring regarding activities related to child passenger safety activities.		X		X
2. Distributing child safety seats with child passenger safety education.			X	
3. Installing smoke detectors with fire safety education.			X	

4. Working with communities on infant safe sleep to reduce suffocation and other sleep related deaths.		X		
5. Collaborating with Injury Prevention Section and Office of Child Fatality Review.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Providing training, technical assistance, and monitoring activities related to child passenger safety activities. (Enabling)

Distributing child safety seats throughout Georgia to those in need. (Population-based)

Providing education to parents and other caregivers on child passenger safety and how to correctly install car seats. (Enabling)

Installing smoke detectors in high-risk households in Georgia. (Population-based)

Providing fire safety education to high-risk households in Georgia. (Enabling)

Working with communities on infant safe sleep to reduce suffocation and other sleep related deaths. (Enabling)

Providing technical assistance to Safe Kids Georgia and its local coalitions (Safe Kids' mission is to prevent unintentional injuries and unintentional injury-related deaths to youth 14 years of age or younger. (Enabling)

c. Plan for the Coming Year

Continue providing training, technical assistance, and monitoring regarding activities related to child passenger safety activities.

Continue distributing child safety seats throughout Georgia to those in need.

Continue providing education to parents and other caregivers on how to correctly install child seats and about proper seatbelt usage.

Continue installing smoke detectors in high-risk households in Georgia.

Continue providing fire safety education to high-risk households in Georgia.

Continue working with communities on infant safe sleep to reduce suffocation and other sleep related deaths.

Implement interventions recommended in Georgia Childhood Injury Prevention Plan in collaboration with the Office of Child Fatality Review.

Continue providing technical assistance to Safe Kids Georgia and its local coalitions.

State Performance Measure 4: *Percent of Medicaid and PeachCare (S-CHIP) enrolled children who received preventive oral health services.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			33	34.3	34.4
Annual Indicator	34.3	38.2	38.2	38.2	38.2
Numerator	479137	538972	538972	538972	538972
Denominator	1398635	1412423	1412423	1412423	1412423
Data Source					Unavailable
Is the Data Provisional or Final?				Final	Provisional
	2009	2010	2011	2012	2013
Annual Performance Objective	40	40	40	40	40

Notes - 2008

Per the Georgia Health Policy Institute, Medicaid/SCHIP data has not been received from the CMOs since they started in July 2006. Data reported is FY 2005 data. Data still is not available

Notes - 2007

Per the Georgia Health Policy Institute, Medicaid/SCHIP data has not been received from the CMOs since they started in July 2006. Data reported is FY 2005 data.

Notes - 2006

FY 2006 data is not yet available.

a. Last Year's Accomplishments

Continued clinical operations reporting. Both public health and private providers must document numbers of children seen and capacity to enroll more children. (Infrastructure)

Through Well Child Team, collaborated with DCH to monitor preventive health services activity. (Infrastructure)

Through Public Health Well Check Outreach monitoring reports, captured information on enrolled children in district quarterly reports. (Infrastructure)

Continued to educate parents on the importance of primary care physician visits, immunizations, and safety factors. (Enabling)

Held Oral Health Access to Care Forum for Head Start population. (Enabling)

Provided dental professional education on fluoride varnish to prevent early childhood caries in high risk very young children (ages 6 months to five years). (Enabling)

Expanded school based mobile dental Georgia Oral Disease Prevention Program. (Infrastructure)

Developed Medicaid and SCHIP Care Managed Organization contracts statewide. (Infrastructure)

Conducted Head Start survey. Report is being shared with partners. (Infrastructure)

Shared best practice information at Head Start Forum in May 2007. (Enabling)

In collaboration with MCGSD, secured workforce development grant to provide senior dental students with public health clinic internships in underserved communities. (Infrastructure, Enabling, Direct Care)

Contracted with Georgia Health Policy Center to produce Medicaid and SCHIP service access reports on care provided to children birth to age 19. Published and shared report, which included a 2000-2005 trend analysis and policy brief. (Infrastructure, Enabling)

Collected public health programmatic service data. Produced and shared reports. (Infrastructure)

Developed and tested new programmatic Access database to collect statewide public health program service data. (Infrastructure)

Implemented programmatic Access database in all 18 districts to collect statewide public health program service data. (Infrastructure)

Developed and disseminated Status of Oral Health In Georgia, 2007 -- Summary of Oral Health Data Collected in Georgia report which presents the most current information available on the oral disease burden in Georgia including data from the Georgia Head Start Oral Health Survey, the Georgia 3rd Grade Oral Health Survey, Georgia Behavioral Risk Factor Surveillance System (BRFSS), and the Georgia Comprehensive Cancer Registry (GCCR). The report also highlights groups in the state that are at highest risk of oral health problems and discusses strategies to prevent these conditions and provide access to dental care. Comparisons are made with national data whenever possible and with the Healthy People 2010 Objectives when appropriate. (Infrastructure)

Developed and submitted Centers for Disease Control and Prevention (CDC) State-Based Oral Disease Prevention Program grant application. Purpose of funding is to assist states in establishing, strengthening, and enhancing the infrastructure and capacity of states to plan, implement, and evaluate population-based disease prevention and promotion programs. Application was funded and implementation of grant funded activities has been initiated. (Infrastructure)

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Visiting elementary schools to conduct screenings on children, place sealants when needed, and provide prevention services, education, and fluoride treatments.	X			
2. Continuing provision of technical assistance and monitoring to district mobile dental trailer program to provide fillings and minor oral surgery services at elementary school sites.				X
3. Continuing implementation of statewide surveys that measure oral health status and continuation of infrastructure building through grant funded school district projects.				X
4. Continuing statewide sharing of Best Practices developed through GADS projects.				X
5. Continuing to provide ongoing consultative support and technical assistance to the districts.				X
6. Continuing efforts to adjust salaries for district dental clinical staff.				X
7. Continuing efforts to build and strengthen infrastructure through school-based/linked program expansion.				X
8. Continuing trainings for school and public health nurses on oral disease prevention and how to provide dental screenings.		X		X
9. Evaluating access to care for Medicaid/PeachCare enrolled				X

children through Georgia Health Policy contract to analyze claims data.				
10. Building community and professional collaborations that increase access to care and support Georgia Oral Health Program.				X

b. Current Activities

Continuing to offer school-based preventive dental services such as sealants, fluoride varnish and rinses, dental screenings and referrals in all 18 health districts, as well as comprehensive dental care. First priority is given to children who need emergency dental services and who are eligible for the Free and Reduced Meal Program (185% Federal Poverty Level). (Direct care)

Providing dental training to school nurses and WIC nutritionists. (Infrastructure)

Implementing CDC funded State-Based Oral Disease Prevention Program Phase I activities to strengthen the state's infrastructure and capacity to plan, implement, and evaluate population-based prevention and promotion programs. (Infrastructure)

c. Plan for the Coming Year

Continue to provide school-based preventive dental services and comprehensive dental care.

Continue to provide dental training to school nurses and WIC nutritionists.

Continue to implement CDC funded State-Based Oral Disease Prevention Program Phase I activities to strengthen the state's infrastructure and capacity to plan, implement, and evaluate population-based prevention and promotion programs.

State Performance Measure 5: *Percent of women of reproductive age who consume at least 400mcg of folic acid daily*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			45	46	47
Annual Indicator	45.3	45.3	45.3	43.3	43.3
Numerator					
Denominator					
Data Source					BRFSS
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	48	49	50	50	50

Notes - 2008

2006 is the most recent year that Georgia included the folic acid module in BRFSS.

Notes - 2007

2006 is the most recent year that Georgia included the folic acid module in BRFSS. A numerator and denominator were not provided.

Notes - 2006

BRFSS, Percent of Women Ages 18-44 Who Take a Folic Acid Supplement - Results for 2006 have not been published as of 6/18/07

a. Last Year's Accomplishments

Continued to promote preconceptional health through provision of educational materials to physicians, nurses, and women of childbearing age. (Enabling)

Participated in statewide Georgia Folic Acid Coalition meetings. (Infrastructure)

Organized Folic Acid Committee at DHR that includes members from Nutrition, PPE< Epi, Women's Health, and ICH teams. (Infrastructure)

Provided formal response to state senator on reducing the number of pregnancies with folic acid preventable still births and anencephaly over the next five years. (Infrastructure)

Outlined strategy for media campaign, professional education, vitamin supplementation, and surveillance and evaluation. (Infrastructure)

Conducted 6 month supplementation/education pilot, with 44,501 bottles of multivitamins distributed. Clients in one clinic in each of 18 health districts and Grady Hospital surveyed. Survey findings indicated 78% had no previous multivitamins, 17% took multivitamins daily and 4% took them every other day; 85% were given multivitamins during their visit; 96% indicated the importance of folic acid/multivitamins was explained during their visit; and 84% received brochures and/or other learning materials explaining importance of folic acid. (Enabling, Infrastructure)

Held "Improving Birth Outcomes -- Shifting the Paradigm" conference that included presentations on providing comprehensive women's health services. (Enabling)

Posted RFP for adaptation of Preconception Health Toolkit for providers. The toolkit is disseminated to professional medical association members and health district staff to promote provision of preconception health care. (Enabling)

Included preconception care deliverables in GA AFP contract, focused on assessing and improving knowledge, attitudes, and practice of preconception care. (Infrastructure)

Collaborated with Emory University to submit proposal to develop and pilot reproductive planning tool in primary care clinic settings. (Infrastructure)

Reconvened and renamed Georgia's Folic Acid Coalition to the MCH Nutrition Advisory Council to represent a broader approach to assuring the optimal nutrition status of reproductive-aged women. First Advisory Council meeting was held on June 12, 2008 and included representatives from multiple state and district agencies and non-profit organizations, including the Georgia Chapter of AAP, GAFFP, March of Dimes, various Public Health District personnel, the University of Georgia, Southeastern United Dairy Association, Department of Community Health Medicaid staff, representatives from the three Medicaid Care Management Organizations, and state-level personnel from the WIC Section and Nutrition Services Unit of OBO. (Infrastructure)

Included a recommendation to health districts to include multiple vitamin (containing 400 mcg of folic acid) client dissemination program in Public Health Enhancement packets submitted to state by districts who want to initiate "birth outcome-oriented" projects. This general recommendation will potentially direct resources toward replicating Women's Health's folic acid supplementation/education pilot program for at risk MCH populations. (Infrastructure)

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participating in statewide WIC Clinical Nutrition trainings.				X
2. Leading the Maternal and Child Health Nutrition Advisory Council, which promotes the importance of adequate daily consumption of folic acid.				X
3. Seeking infrastructure building opportunities to implement folic acid supplementation and nutrition education programs as a complement to the Georgia WIC program.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Through state-level nutrition consultants, promoted importance of consuming folic acid rich foods and/or taking a supplement at State Office Building (houses Department of Human Resources and Department of Community Health) during National Folic Acid Awareness week (January 2009). (Enabling)

Continuing to promote practice of counseling women of reproductive age who participate in the Georgia WIC program on the importance of adequate daily folic acid consumption. (Enabling)

Engaged external partners (e.g., March of Dimes) participating in the informal Maternal and Child Health Nutrition Council by providing general advisement on the nutritional importance of adequate folic acid consumption. Also brainstormed ideas to build infrastructure within Georgia to support provision of evidence-based nutrition counseling (i.e., folic acid and Omega-3 fatty acid consumption) for women of reproductive age that complements WIC program activities. (Infrastructure)

c. Plan for the Coming Year

Continue to promote nutrition counseling by Georgia's public health nutritionists that promotes adequate folic acid for women of reproductive age.

Continue efforts to ensure that OBO target population groups receive education and information on the importance of consuming folic acid daily.

Continue to seek infrastructure building opportunities that support a broader base of nutrition counseling for Georgia women of reproductive age.

Continue to provide strategic leadership in galvanizing external partners, including providing technical assistance and advice to the MCH Nutrition Advisory Council on the interpretation of current nutrition science regarding optimal health and nutrition status for reproductive aged women.

Continue to plan and carry out adequate folic acid consumption promotional events during National Folic Acid Awareness week and other relevant opportunities.

State Performance Measure 6: *Percent of repeat births among adolescents aged 15-17-years-old*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			10.6	10.6	10.5
Annual Indicator	10.7	9.9	9.9	10.0	11.1
Numerator	579	522	522	577	639
Denominator	5404	5260	5260	5785	5756
Data Source					Vital Records
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	10.5	10.4	10.4	10.4	10.4

Notes - 2006

2006 data is not yet available and will be provided in the FY 2009MCHGB.

a. Last Year's Accomplishments

Collaborated with other state agencies, DPH/FHB programs, and partners to implement: 1) statewide network of preventive health and youth development services; 2) approaches targeted to key adolescent health issues; 3) adult/professional education and development programs; 4) state and local partnerships; 5) expanded health care access for youth; 6) alternative learning environments and approaches; and 7) community outreach and involvement. (Infrastructure)

Provided web-based training on Youth Assets Development for health care professionals. (Enabling)

Expanded BART teen surveillance survey. (Infrastructure)

Standardized AHYD client data systems. (Infrastructure)

Standardized AHYD Grant-in-Aid quarterly reporting systems. (Infrastructure)

Reinstated internal workgroup to develop a statewide initiative to prevent repeat births. (Infrastructure)

Collected and analyzed state teen pregnancy data. (Infrastructure)

Disseminated federal data (includes Georgia data) on repeat teen pregnancies to health districts. (Infrastructure)

Increased public awareness through newspaper articles in key state papers and television. (Enabling)

Held joint meeting between Family Planning and Adolescent Health and Youth Development (AHYD) staff to review data and identify strategies. Joint work has been informed by a 2006 Family Health Branch analysis of strategies to reduce teen pregnancies as well as AHYD's annual work plan activities, which included activities to reduce teen pregnancy. (Infrastructure)

Reviewed Family Planning trend analysis findings and FBH "Approaches to Prevent Additional

Pregnancies in Teens" report to identify strategies that can be implemented by Family Planning programs. (Infrastructure)

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Using data to target interventions.				X
2. Working closely with organizations and agencies that serve pregnant teens.				X
3. Continuing to refocus nontraditional sites to address repeat pregnancies.				X
4. Implementing and expanding parent education.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Collaborated at the district level, on joint AHYD and Family Planning activities for Let's Talk Month (October) and Teen Pregnancy Prevention Month (May). State Family Planning program required that activities be identified in district work plans. Districts report progress quarterly.

Provided Family Planning and AHYD technical assistance to districts implementing activities to reduce repeat teen pregnancies. (Infrastructure)

c. Plan for the Coming Year

Continue to collect and disseminate data and information on best practices and strategies to reduce repeat teen births at the state, regional, and local level.

Provide health districts with training and technical assistance on strategies and best practices to reduce repeat teen births.

Continue to plan and implement activities at the district and health department level around Let's Talk Month (October) and Teen Pregnancy Prevention Month (May).

Promote and support sharing of knowledge, experience, and lessons learned among district women's health coordinators regarding strategies to reduce repeat teen births.

State Performance Measure 7: *Rate of SIDS among African American infants.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
---------------------------------------	------	------	------	------	------

Annual Performance Objective			1.2	1.2	1.1
Annual Indicator	1.3	1.2	1.2	1.6	1.7
Numerator	59	53	53	77	83
Denominator	43721	45457	45457	49048	48401
Data Source					Vital Records
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	1.1	1	1	1	1

Notes - 2006

2006 Data is not yet available and will be provided in the FY 2009 MCHBG.

a. Last Year's Accomplishments

Performed high risk infant developmental assessment (ASQ) to facilitate early identification of delays and referrals. (Direct Health Care)

Developed assessment tool to assist in determining the knowledge, attitudes, and beliefs of African American caretakers with regard to evidence-based safe sleep practices. (Infrastructure)

Assessed the knowledge, attitudes, and beliefs of African American caretakers with regard to evidence-based safe sleep practices. (Infrastructure)

Developed SIDS risk reduction measures, including providing cribs to families at highest risk. (Enabling)

Incorporated SIDS and other infant sleep related deaths trainings in crib matching initiative. (Enabling)

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assisting parents of HRIFU infants to obtain cribs for infants when families do not have one		X		
2. Teaching all parents of HRIFU infants about safe infant sleeping positions.		X		
3. Securing and disseminating educational materials.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Identifying and providing education to at risk populations for SIDS as part of the overall assessments or evaluations completed at the time of entry into CYSN and CMS programs. (Enabling)

Continuing to hold genetics clinics in five health districts outside of the metropolitan Atlanta area (where geneticists are located). During the clinics, children who are at risk of SIDS (i.e., family history, children's medication condition) are identified and child's family is provided with SIDS

education. (Direct care, enabling)

c. Plan for the Coming Year

Continue to provide identification and education services to at risk children seen in the Children 1st program, CYSN, UNBHS, and Genetics Clinics.

State Performance Measure 8: *Percentage of Medicaid children who have had a developmental screening*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			75	75	76
Annual Indicator					
Numerator					
Denominator					
Data Source					Unavailable
Is the Data Provisional or Final?				Provisional	Provisional
	2009	2010	2011	2012	2013
Annual Performance Objective	76	77	77	77	77

Notes - 2008

It is 19.0%. The data source is the National Survey of Children's Health, 2007. A numerator and denominator are not available.

Notes - 2007

Data is currently being reevaluated & is not available.

Notes - 2006

Data is not collected for this measure.

a. Last Year's Accomplishments

Formed Developmental Screening Workgroup that includes members from DPH, CDC, GA AAP, GAFFP, and DCH. Workgroup reviewed existing standards and evidence-based developmental screening standards. (Infrastructure)

Developed Babies Or Older Surveillance Templates (BOOST), adapted from the Bright Futures Anticipatory Guidelines, for developmental surveillance. The templates were developed to assist in meeting Medicaid's requirement for developmental screening and family health counseling as required during EPSDT service for children 0-21 years of age and during all other routine child exams. (Infrastructure)

Recommended statewide developmental screening protocols. (Infrastructure)

Began promoting statewide developmental screening protocols and provide training for public and private providers. (Enabling)

Continued Well Child Team documentation of public health and private provider practice developmental screening reviews. DCH and GA AAP strongly encouraged use of developmental screening (Infrastructure)

Continued Well Child Team monitoring of use of Ages and Stages Questionnaire (ASQ) training throughout the state. Promoted practice with applicable training sessions, including Baby Basics

and Health Check updates. (Enabling)

Provided public health nurses with ASQ training for use in the Integrated Family Support project. (Enabling)

Made presentations to early childcare staff at GAYC and Bright from the Start conferences on child development and social/emotional development. (Enabling)

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Providing education to support developmental screening.				X
2. Working in collaboration with medical organizations, patient groups, and early childhood agencies to promote developmental screening.				X
3. Monitoring by chart review during Health Check site visits.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Adopted Ages and Stages Questionnaire as DPH's developmental screening tool for programs serving young children ages birth to five years. (Enabling)

Hired developmental specialists for all 18 health districts to assist with developmental screening and referrals. (Infrastructure)

Working to place trainers in each of the state's 18 public health districts. (Infrastructure)

Providing Birth to Five system training to state public health staff, stakeholders, and communities on use of Ages and Stages Questionnaire/ developmental screen and on how to refer children identified with concerns. (Enabling)

Determining developmental screening status of children with suspected delay referred to Children 1st. Birth to Five Systems (Children 1st, HRIFU, CMS or Child Health) completes MCH Integrated Assessment for children who have received a standardized developmental screening. The screening results, assessment, and referral are forwarded to BCW. Birth to Five completes the MCH Integrated Assessment and standardized developmental screening for children who have not received a standardized developmental screening. Results and referral sent to BCW. (Direct)

Identifying and providing education to at risk population for SIDS as part of the overall assessments or evaluations completed at the time of entry to CYSN and CMS programs. (Direct)

c. Plan for the Coming Year

Develop evidence-based/best practice universal developmental screening plan.

Identify and recommend strategies to finance universal developmental screening.

Enhance and expand developmental screening communications vehicles.

Increase education and training around developmental screening for parents/families, health care providers, early care and learning providers, family support/social support providers, and other key stakeholders.

Implement evidence-based/best practice universal developmentally screening.

State Performance Measure 9: *The percent of MCH state and local public health staff that have completed the Public Health 101 course.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			8.5	9	9.5
Annual Indicator		8.2	8.2	8.2	8.2
Numerator		95	95	95	95
Denominator		1158	1158	1158	1158
Data Source					Workforce Development
Is the Data Provisional or Final?				Provisional	Provisional
	2009	2010	2011	2012	2013
Annual Performance Objective	10	10.5	11	11	11

Notes - 2008

This course has been internally developed and was initially provided during the past year. We are currently in pilot stage of the rollout which targets local level staff. Additional course offerings will be available for state office staff beginning during the next few months. We anticipate a significant increase in staff participation in the coming months and years.

Notes - 2007

The curriculum is being revised. Other courses were offered in the interim but full implementation of Public Health 101 will occur in the coming months and will be reported in the FY 2010 MCHBG.

Notes - 2006

The curriculum has just been finalized. Other courses were offered in the interim but full implementation of Public Health 101 will occur in the coming months and will be reported in the FY 2009 MCHBG.

a. Last Year's Accomplishments

Secured contractor to coordinate and plan trainings offered to state and district/county staff on various MCH nutrition and health related topics. (Infrastructure)

Worked on local coalition development and sustainability (focus on nutrition, physical activity, and obesity related coalitions. (Infrastructure)

Assessed training and technical assistance needs. (Infrastructure)

Provided technical assistance to health districts. (Enabling)

Provided Ages and Stages training and Baby Basics workshops. (Enabling)

Provided public health and private providers (via contracts with medical associations) with preconception health education. (Enabling)

Contracted with Georgia Southern University to provide competency-based training to the MCH/WIC workforce on childhood obesity, children with special needs, lactation skills workshop, and preconception health and social marketing. Approximately 350 public health staff participated in statewide trainings. (Infrastructure)

Initiated the "pilot" year-long EDLI Initiative for state and district PH Leadership. (Enabling)

In compliance with Presidential Directive HSPD-5 issued to the Department of Homeland Security to create and administer a National Incident Management System (NIMS), DHR adopted and uses the NIMS through response, exercises, and training. To assist employees in being compliant for ICS 100, 200, and 700, training included an introduction to the principles, common terminology and position-specific responsibilities when responding to an event using the ICS.(Enabling)

Revised the Public Health 101 course; pilot tested revised course curriculum. (Infrastructure)

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Providing training to state and district/county staff on various MCH nutrition and health related topics throughout the year.				X
2. Participating in local coalition development and sustainability (focusing on nutrition/physical activity/obesity related coalitions.)				X
3. Providing technical assistance to health districts.				X
4. Providing training for Oral Health staff on infection control, disease management, computer systems, and programmatic management skills development. Continuing education credits are required for professional licensure.				X
5. Providing Public Health and School Nurses with dental screening training.				X
6. Providing training updates on Bright Futures Health Supervision Guidelines for Infants, Children and Adolescents during Health Check review visits.				X
7. Providing training on Development Ages and Stages Questionnaire.				X
8.				
9.				
10.				

b. Current Activities

Held Georgia Infant Mortality Summit in December, 2008

Developed train-the trainer workshop on "Understanding and Implementing SB529 (verification of lawful presence in the U.S. for any person 18 years of age or older)" for public health districts and a self-paced training course for state office staff. (Infrastructure)

Revised educational materials to reflect changes DPH made in its guidance concerning immigrant access to public health services. (Infrastructure)

Provided training on SB529. (Enabling)

c. Plan for the Coming Year

Significant training to pediatric providers (public and private) on serving children with special needs, focusing on early intervention services, including developmental screening is planned.

Training to public health staff on social-emotional development for children zero to eight is planned.

State Performance Measure 10: *The extent to which partnerships that support Early Childhood Comprehensive Systems (ECCS) are effective.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			60	65	70
Annual Indicator		57.1	68.6	68.6	71.4
Numerator		20	24	24	25
Denominator		35	35	35	35
Data Source					CCH Program
Is the Data Provisional or Final?				Provisional	Provisional
	2009	2010	2011	2012	2013
Annual Performance Objective	75	80	85	85	85

a. Last Year's Accomplishments

Developed partnership with the Department of Early Care and Learning (/DECAL) to support implementation of Georgia's nutrition and physical activity plan. (Infrastructure)

As part of DECAL Nutrition Education Committee, assisted in the development of November 2005 Nutrition and Physical Activity Summit. (Infrastructure)

Provided hands-on interactive workshop on nutrition and nutrition education in early child care settings. (Enabling)

Achieved agreement/buy-in from DECAL to implement two objectives from Georgia's Nutrition and Physical Activity Plan related to early child care plan. (Infrastructure)

Developed nutrition and physical activity logic model with DECAL. (Infrastructure)

Developed training plan related to nutrition and physical activity (classroom curriculum grades 3-5, food service and improving the nutrition and physical activity environment). (Infrastructure)

Developed a proposal to sustain Healthy Childcare Georgia. (Infrastructure)

Provided technical assistance and consultation to DECAL staff in the development of a nutrition and physical activity resource and training web page. (Infrastructure)

Developed survey related to current nutrition and physical activity interventions within DECAL (state and local) as well as staff barriers to implementing nutrition and physical activity programs.

(Infrastructure)

As part of Georgia's Obesity Prevention Initiative, formed subcommittee of partners to address early child care setting. Partners include DECAL, DHR, Children's Healthcare of Atlanta, the University of Georgia Cooperative Extension, and International Life Sciences Institute (ILSI) Center for Health Promotion. (Infrastructure)

Through five workgroups that include stakeholder and consumer participants, continued to implement ECCS priority area activities. (Enabling)

Funded ECCS cross cutting clearinghouse, navigator team, training, public awareness, and developmental screening activities, including development and implementation of web-based ECCS clearinghouse. (Infrastructure)

Established ECCS Finance Subcommittee. Received technical assistance from Kay Johnson of National Center for Children in Poverty on ECCS financing strategies. (Infrastructure)

Received update on PeachCare for Kids and Medicaid coverage in Georgia at ECCS Steering Committee meeting. Medicaid director discussed current challenges, including the federal PeachCare shortfall as well as the increasing number of uninsured Georgia children that need health insurance coverage as the state's population continues to grow. (Enabling)

Conducted train-the-trainer on nutrition and physical activity for 0-5 (classroom curriculum). (Enabling)

Developed food service and menu planning training and content. (Infrastructure)

Developed training on the assessing and improving the nutrition and physical activity environment in early child care centers (e.g., NAPSACC tool). (Enabling)

Assisted DECAL in maintaining appropriate content of nutrition and physical activity website. (Enabling)

Submitted application to USDA for team nutrition grant. (Infrastructure)

Identified five cross-cutting focus areas. Provided funding to support cross-cutting area activities. (Infrastructure)

Populating ECCS web-based clearinghouse. (Infrastructure)

Provided mini grants to ECCS work groups. (Infrastructure)

Provided ECCS training for Navigator Teams. (Enabling)

Expanded Navigator Team focus from families with children with special needs to all families. (Infrastructure)

Expanded number of Navigator Teams from 10 to 30. (Infrastructure)

Developed and initiated Navigator Team evaluation study. (Infrastructure)

Provided Better Brains for Babies training. (Enabling)

Formed Georgia ECCS Partnership/State Team. Team members participated in national meeting in February 2008. (Infrastructure)

Presented on "medical/dental home" at annual Bright From the Start Conference. (Enabling)

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assisting DECAL in maintaining appropriate content of nutrition and physical activity web site.				X
2. Providing input and technical assistance on menu planning, general nutrition, and physical activity tools and training.				X
3. Providing leadership to ECCS grant, steering committee, and work groups.				X
4. Implementing MOUs/subcontracts for ECCS cross cutting activities (i.e., clearinghouse, developmental screening, training, and public awareness).				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Supported a family support practice study to examine current family support practices and training for state agency personnel who provide services for young children and families, evidence-based best practices related to family support, and strengths, gaps, and barriers related to current practices and training in Georgia. (Infrastructure)

Continued to expand the ECCS web-based clearinghouse to provide early childhood related information and web-based links for consumers and for early childhood providers. (Enabling)

Funded expansion and training of navigator teams. (Infrastructure)

Continued efforts to strengthen partnerships around ECCS principles and elements and to improve the lives of young children and their families. (Infrastructure)

An attachment is included in this section.

c. Plan for the Coming Year

Actively foster partnership development.

Identify early childhood five core content resources, gaps, and barriers in Georgia.

Identify early childhood social emotional resources, gaps, and barriers in Georgia.

Identify, develop and implement early childhood policies strategies, with emphasis on social emotional competence/well-being.

Develop and implement communications/advocacy strategies to inform families; health, early care and education and family support providers; the public; and other childhood partners.

Develop evidence-based/best practice universal developmental screening plan.

Identify and recommend strategies/resources to finance universal developmental screening.

Enhance/expand developmental screening communications vehicles.

Increase education/training around developmental screening for parents/families, health care providers, early care and learning providers, family support/social support providers, and other key stakeholders.

Continue to populate web-based ECCS clearinghouse.

E. Health Status Indicators

Introduction

/2007/ The health status indicators direct the work of DPH in the following ways:

- Program development: The indicators have informed and assisted in directing FHB efforts such as the Branch's preconception health initiative and the development of a state perinatal plan, consumer and provider education, health promotion materials, web site development, folic acid distribution, contracts with provider organizations, and newsletter articles.

- Program assessment and enhancement: Examples include updating of tertiary center core requirements, focusing on enhancement and improvement of outreach education and developmental follow-up of newborns.

- Resource allocation: Acquisition and distribution of resources such as child safety kits through Children 1st have been informed by the health status indicators. Initiatives such as FOCUS, a data-driven community approach to addressing infant mortality in selected counties, have also been guided by health status indicator data.

- Monitoring, technical assistance, and quality assurance: Key performance indicators of measures of program process performance and are linked to health status indicators through logic models and program plans. These measures are used as triggers for technical assistance and quality assurance. //2007// **/2010/ Effective July 1, 2009, OBO (formerly FHB), became the Office of Maternal and Child Health./2010/**

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	9.3	9.4	9.4	9.6	9.1
Numerator	12886	13301	13301	14209	13711
Denominator	138561	140903	140903	148403	150804
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2006

2006 data not yet available

Narrative:

#01A. The percent of live births weighing less than 2,500 grams - This indicator is used for surveillance and monitoring of poor birth outcomes in Georgia. The Office of Health Information and Policy (OHIP) has developed an online web tool for querying Vital Statistics and Hospital Discharge data. Low birth weight is one of the indicators contained within these data. The MCH Epidemiology Section produces the Reproductive Health Indicators Report that provides trend data by race/ethnicity, public health district and perinatal region to monitor key indicators of reproductive health, including low birth weight. In addition, the prevalence of low birth weight is calculated for geographical and population subgroups to provide information that is used to target resources and to develop interventions addressed at increasing birth weight. Low birth weight has also been used as an outcome in the evaluation of public health programs, including WIC, Medicaid Perinatal Case management, and Babies Born Healthy.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	7.6	7.7	7.7	7.8	7.4
Numerator	10138	10444	10444	11155	10779
Denominator	134061	136440	136440	143425	145900
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2006

2006 data is not yet available

Narrative:

#01B. The percent of live singleton births weighing less than 2,500 grams - Same as 1A.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	1.8	1.8	1.8	1.8	1.8
Numerator	2524	2563	2563	2682	2647
Denominator	138561	140903	140903	148403	150804
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2006

2006 data not yet available

Narrative:

#02A. The percent of live births weighing less than 1,500 grams - Same as 1A. In addition, MCH Epidemiology analyzes the level of care of hospitals where babies weighing less than 1,500 grams are born to monitor the effectiveness of the regional perinatal system in ensuring that all women are receiving the appropriate level of care.

/2010/ Approximately 76% of all very low birth weight babies are born in risk-appropriate perinatal hospitals in Georgia each year. Of that number, 45% are born in the Designated Regional Perinatal Centers. The goal is to increase the overall percentage of very low birth weight babies born in a risk-appropriate facility to 92% by 2020./2010//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	1.5	1.4	1.4	1.4	1.4
Numerator	1973	1973	1973	2064	2018
Denominator	134061	136440	136440	143425	145900
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2006

2006 data is not yet available

Narrative:

#02B. The percent of live singleton births weighing less than 1,500 grams - Same as 1A.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	11.2	9.0	9.0	9.1	8.7

Numerator	219	177	177	185	184
Denominator	1954254	1969278	1969278	2035969	2109362
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2006

Data for 2006 is not yet available

Narrative:

#03A. The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger - This indicator is used for surveillance and monitoring of years of potential life lost in children due to injury. OHIP has developed an online web tool containing Vital Statistics and Hospital Discharge data. OASIS is a flexible tool that allows for querying of several variables including cause of death, cause of hospitalization, and the age. The Chronic Disease, Injury, and Environmental Health Epidemiology Section conducts surveillance and reports on injury, risks, leading causes of death, and morbidity.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	4.6	3.5	3.5	4.2	3.6
Numerator	89	69	69	85	75
Denominator	1954254	1969278	1969278	2035969	2109362
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2006

2006 data is not yet available

Narrative:

#03B. The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among children aged 14 years and younger - Same as 3A.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	25.4	27.0	27.0	30.7	31.7
Numerator	325	355	355	409	421
Denominator	1279920	1313523	1313523	1333619	1326310
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2006

2006 data is not yet available

Narrative:

#03C. The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years - Same as 3A.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	154.9	149.1	149.1	141.9	119.7
Numerator	3028	2937	2937	2890	2524
Denominator	1954254	1969278	1969278	2035969	2109362
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2006

2006 data is not yet available

Narrative:

#04A. The rate per 100,000 of all non-fatal injuries among children aged 14 years and younger - Same as 3A.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	39.4	33.3	33.3	36.4	28.7
Numerator	770	655	655	741	605
Denominator	1954254	1969278	1969278	2035969	2109362
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2006

2006 data is not yet available

Narrative:

#04B. The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger - Same as 3A.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	153.4	151.3	151.3	153.2	152.5
Numerator	1964	1987	1987	2043	2022
Denominator	1279920	1313523	1313523	1333619	1326310
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2006

2006 data is not yet available

Narrative:

#04C. The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years - Same as 3A.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	34.9	32.6	39.6	36.5	27.5
Numerator	10599	10258	12438	11918	9057
Denominator	303451	314220	314220	326722	329199
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008

Note: 2007 data was revised as reported by Notifiable Disease.

Notes - 2007

The reported cases of Chlamydia is based on CY06 reports, while the denominator is based on 2006 population due to the lag in U.S. Bureau of Census Population estimates

Notes - 2006

The reported cases of Chlamydia is based on CY06 reports, while the denominator is based on 2005 population due to the lag in U.S. Bureau of Census Population estimates

Narrative:

#05A. The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia - This indicator is used for surveillance and monitoring of STDs and women's health. Chlamydia is a reportable disease and these data have been available on the Public Health website for several years. STD data has been recently added to the OASIS web query tool. Data can be queried by disease and age of the case. The STD Epidemiology Section conducts surveillance and produces reports on the prevalence and incidence of Chlamydia in Georgia.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	8.2	9.4	8.6	8.2	7.3
Numerator	16237	18842	17657	17113	15282
Denominator	1987175	2003939	2056786	2083969	2096371
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average					

cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

The reported cases of Chlamydia is based on CY06 reports, while the denominator is based on 2006 population due to the lag in U.S. Bureau of Census Population estimates

Notes - 2006

The reported cases of Chlamydia is based on CY06 reports, while the denominator is based on 2005 population due to the lag in U.S. Bureau of Census Population estimates

Narrative:

#05B. The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia - Same as 5A.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	152919	95057	48401	585	4279	227	4370	0
Children 1 through 4	584503	359672	192385	1620	17006	487	13333	0
Children 5 through 9	695502	430528	226397	2367	19026	708	16476	0
Children 10 through 14	676438	407181	235274	2369	17788	637	13189	0
Children 15 through 19	679005	402778	247336	2410	15884	554	10043	0
Children 20 through 24	647305	395670	224805	15328	2680	615	8207	0
Children 0 through 24	3435672	2090886	1174598	24679	76663	3228	65618	0

Notes - 2010

Narrative:

#06 A & B. Infants and children aged 0 through 24 years enumerated by maternal age, race, and ethnicity - This indicator is used to monitor population trends to understand demographic changes in Georgia and best target resources.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY	Total NOT Hispanic	Total Hispanic	Ethnicity Not
-----------------	---------------------------	-----------------------	----------------------

TOTAL POPULATION BY HISPANIC ETHNICITY	or Latino	or Latino	Reported
Infants 0 to 1	127052	25867	0
Children 1 through 4	501614	82889	0
Children 5 through 9	618158	77344	0
Children 10 through 14	618622	57816	0
Children 15 through 19	632162	46843	0
Children 20 through 24	591363	55942	0
Children 0 through 24	3088971	346701	0

Notes - 2010

Narrative:

#06 A & B. Infants and children aged 0 through 24 years enumerated by maternal age, race, and ethnicity - This indicator is used to monitor population trends to understand demographic changes in Georgia and best target resources.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Total live births								
Women < 15	293	96	189	2	1	0	5	0
Women 15 through 17	5756	2801	2782	15	32	6	120	0
Women 18 through 19	12287	6377	5490	24	104	12	280	0
Women 20 through 34	113365	68296	37468	297	4236	137	2931	0
Women 35 or older	19103	12152	5219	40	1131	17	544	0
Women of all ages	150804	89722	51148	378	5504	172	3880	0

Notes - 2010

Narrative:

#07A & B. Live births to women (of all ages) enumerated by maternal age, race, and ethnicity - This indicator is used to monitor the trends in births and understand demographic changes in Georgia and best target resources.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Women < 15	234	50	9
Women 15 through 17	4599	1065	92
Women 18 through 19	10179	1860	248
Women 20 through 34	92406	19168	1791
Women 35 or older	16477	2332	294
Women of all ages	123895	24475	2434

Notes - 2010

Narrative:

#07A & B. Live births to women (of all ages) enumerated by maternal age, race, and ethnicity - This indicator is used to monitor the trends in births and understand demographic changes in Georgia and best target resources.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	1198	524	654	3	15	2	0	0
Children 1 through 4	196	101	87	1	4	0	3	0
Children 5 through 9	103	60	42	0	1	0	0	0
Children 10 through 14	116	59	51	0	5	0	1	0
Children 15 through 19	516	300	207	2	6	0	1	0
Children 20 through 24	757	467	281	0	8	1	0	0
Children 0 through 24	2886	1511	1322	6	39	3	5	0

Notes - 2010

Narrative:

#08A & B. Deaths to infants and children aged 0 through 24 years enumerated by age subgroup, race and ethnicity - This indicator is used to monitor the burden of death in children and variation by subpopulations to target resources. MCH Epidemiology conducts analyses of infant deaths to

identify groups at highest risk and to identify risk factors that may be potentially modifiable. Results from these analyses are being used to target intervention efforts in communities with the highest rates of infant death and to focus efforts on effective interventions.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Total deaths			
Infants 0 to 1	1119	75	4
Children 1 through 4	14	182	0
Children 5 through 9	95	7	1
Children 10 through 14	110	6	0
Children 15 through 19	482	30	4
Children 20 through 24	698	56	3
Children 0 through 24	2518	356	12

Notes - 2010

Narrative:

#08A & B. Deaths to infants and children aged 0 through 24 years enumerated by age subgroup, race and ethnicity - This indicator is used to monitor the burden of death in children and variation by subpopulations to target resources. MCH Epidemiology conducts analyses of infant deaths to identify groups at highest risk and to identify risk factors that may be potentially modifiable. Results from these analyses are being used to target intervention efforts in communities with the highest rates of infant death and to focus efforts on effective interventions.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown	Specific Reporting Year
Misc Data BY RACE									
All children 0 through 19	2788367	1695216	949793	9351	73983	2613	57411	0	2007
Percent in household headed by	36.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2007

single parent									
Percent in TANF (Grant) families	1.0	22.0	73.4	0.1	0.2	3.9	0.4	0.0	2007
Number enrolled in Medicaid	942817	0	0	0	0	0	0	942817	2007
Number enrolled in SCHIP	328729	0	0	0	0	0	0	328729	2007
Number living in foster home care	3469	0	0	0	0	0	0	3469	2007
Number enrolled in food stamp program	418979	0	0	0	0	0	0	418979	2007
Number enrolled in WIC	350319	107171	148201	1635	7008	0	7947	78357	2007
Rate (per 100,000) of juvenile crime arrests	5.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2007
Percentage of high school drop-outs (grade 9 through 12)	4.1	4.0	4.3	4.5	1.5	0.0	3.6	0.0	2007

Notes - 2010

Racial Breakdown unavailable

Racial breakdown unavailable

Racial breakdown unavailable

Racial breakdown unavailable

Racial breakdown unavailable

Racial breakdown unavailable

Racial breakdown unavailable

Narrative:

#09A & B. Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race and ethnicity - Understanding shifts in utilization of public programs for MCH populations is useful in determining other MCH programmatic needs and the affect on MCH health status.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity.*
(Demographics)

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported	Specific Reporting Year
Miscellaneous Data BY HISPANIC ETHNICITY				
All children 0 through 19	2497608	290759	0	2007
Percent in household headed by single parent	0.0	0.0	36.0	2007
Percent in TANF (Grant) families	0.0	0.0	1.0	2007
Number enrolled in Medicaid	0	0	942817	2007
Number enrolled in SCHIP	0	0	328729	2007
Number living in foster home care	0	0	3469	2007
Number enrolled in food stamp program	0	0	418979	2007
Number enrolled in WIC	271962	78357	0	2007
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	5.1	2007
Percentage of high school drop-outs (grade 9 through 12)	0.0	0.0	5.0	2007

Notes - 2010

Ethnicity breakdown unavailable.

Ethnicity breakdown unavailable.

Ethnicity breakdown unavailable.

Ethnicity breakdown unavailable.

Ethnicity breakdown unavailable.

Ethnicity breakdown unavailable.

Ethnicity breakdown unavailable.

Narrative:

#09A & B. Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race and ethnicity - Understanding shifts in utilization of public programs for MCH populations is useful in determining other MCH programmatic needs and the affect on MCH health status.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	2788367

Living in urban areas	2316856
Living in rural areas	471511
Living in frontier areas	0
Total - all children 0 through 19	2788367

Notes - 2010

Narrative:

#10. Geographic living area for all resident children aged 0 through 19 years - Monitoring of shifts in population in rural and urban areas is helpful in targeting MCH programs.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	9544750.0
Percent Below: 50% of poverty	0.0
100% of poverty	13.6
200% of poverty	32.6

Notes - 2010

This data is unavailable.

Narrative:

#11. Percent of the State population at various levels of the federal poverty level -- Monitoring of childhood poverty is an important indicator of child health and MCH programmatic needs.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	2788367.0
Percent Below: 50% of poverty	0.0
100% of poverty	20.6
200% of poverty	41.6

Notes - 2010

This data is unavailable.

Narrative:

#12. Percent of the State population aged 0 through 19 years at various levels of the federal poverty level - Same as 11.//2007//

F. Other Program Activities

DHR has over 45 information lines; 12 are located in DPH. Several of the DPH toll-free hotlines offer access points in the entire MCH service system. Georgia's Title V toll-free hotline, Powerline, is run by Healthy Mothers, Healthy Babies (HMMB) under a FHB contract. Powerline assists women, pregnant women, parents, health care providers, social service agencies, community organizations, and any other individual or agency experiencing difficulties in obtaining information about health care and/or health care services. The Powerline offers services in English and Spanish. Caseworkers are available Monday-Friday 8:00 AM through 7:00 PM to provide callers with access to information on local general practitioners and medical specialists; local dentists; prenatal healthcare services; low cost healthcare resources for the uninsured; WIC customer service; HIV testing sites; Children 1st; dental, vision, and hearing screening facilities; breastfeeding information resources; other healthcare and public health referrals; and a PeachCare application that can be completed over the phone. In addition, the Powerline maintains the most comprehensive database of Georgia's Medicaid and PeachCare accepting providers, public health programs, and community/low cost health services. For callers not eligible for Medicaid or PeachCare, the hotline provides information on healthcare providers that offer low cost or sliding scale fee services. In 2004, the Powerline assisted 15,526 individuals experiencing difficulties or delays in accessing healthcare services. /2007/ Powerline remains Georgia's only bilingual, toll-free telephone hot line, connecting low-income families to healthcare resources. The hotline maintains Georgia's most extensive database of physicians, dentists, and community clinics that accept Medicaid and offer sliding scale fees. In 2005, Powerline assisted 23,128 callers who were experiencing barriers to health care and community services. Approximately 33% of callers were referred to WIC, 30% to Medicaid physicians and dentists, 25% to other Medicaid providers, and 24% to low-cost health care resources.//2007// /2008/ Powerline received a total of 20,335 calls in FY 2006; 37,158 referrals were made to services, ranging from low cost health care, dentists, childbirth education, to non-emergency transportation and Perinatal Case Management. In addition, the Powerline received 16,645 lactation calls, 17,607 WIC calls and 42 requests for HIV testing sites. Children 1st was promoted as the single point of entry into Public Health services. There were 162 referrals made to the appropriate Children 1st coordinators. Powerline staff visited all 159 Georgia counties to conduct community outreach and ensure public health providers are aware of the Powerline and its services. Promotional materials were disseminated in all 159 counties as well.//2008// /2009/ In FY 2007, Powerline received 15,861 calls; 27,909 referrals were made; and 423 outreach events were conducted. A satellite office was opened in Savannah. /2010/ ***HMMB continues to operate the PowerLine, Georgia's toll-free helpline for healthcare referrals. The PowerLine maintains a database of Georgia's low-cost and sliding-scale providers, free clinics, public health programs, and community health services. Operators are available who speak both Spanish and English and who can assist callers in finding specific providers or programs available to meet their individual needs within their community. The PowerLine also answers the Georgia WIC customer service toll-free telephone line and refers callers to the appropriate WIC Clinic and records reports of complaints or fraud. In addition, PowerLine provides referrals for DPH's Perinatal HIV Prevention Project, Babies Born Healthy, Babies Can't Wait, and Children1st. From 7/1/2008 to 5/18/2009, Powerline received 22,294 calls and 45,332 referrals were made.//2010//***

Before DHR and Behavioral Health Link (BHL) implemented the Georgia Crisis and Access Line (GCAL) Single Point of Entry (1-800-715-4225; mygcal.com) in July 2006, Georgia had as many as 25 substance abuse and mental health crisis access lines and a number of different approaches to providing information. GCAL, which operates 24 hours/7 days a week, uses

clinical staff to assist callers with brief screening and evaluation services as information about services. Mygcal.com allows users to access an online resource base where they can search the GCAL provider resource base by provider, city, and approximate distance of zip code and by core services. GCAL received a SAMHSA Crisis Center award in the large crisis call center category (more than 100,000 calls annually) in 2007. In addition, Commission on Accreditation of Residential Facilities (CARF) awarded BHL the maximum three year accreditation for the new Crisis & Information Call Center credential. BHL is the first organization in the country to receive the Call Center award.//2009//

In 2000, HMHB began working with DPH's HIV Section and Women's Health to help implement the social marketing component of the state's CDC funded Perinatal HIV Transmission Project. The project continues to utilize the Powerline as its access point for women to obtain information on HIV testing and counseling services. The Powerline also continues its relationship with the Georgia SIDS Project and DPH's statewide Universal Hearing Screening and Intervention Initiative by referring callers to these services as needed. In November 2002, Powerline began accepting WIC customer services calls. Powerline staff provide callers with general information about WIC services as well as assistance in locating local WIC offices. Since beginning its partnership with WIC, Powerline has assisted over 14,000 callers. In 2004, Powerline expanded its services and began assisting callers by filling out PeachCare applications over the phone.

Babies Can't Wait (Part C, IDEA) supports a separate toll-free number for families of children with special needs that provides a central directory of public and private early intervention services, research and demonstration projects, professional groups, parent support groups and advocate associations available in the state for children with or at risk for developmental delays or disabilities. This central directory is operated by Parent-to-Parent of Georgia, a statewide parent-run organization. A unique feature of the hotline is that a parent of a child with a disability answers the phone. In addition to obtaining information about services, callers can be matched with supporting parents whose children have similar disabilities. The BCW contract with Parent to Parent also includes elements related to referral and supports for families of children with special needs of all ages. Parent to Parent is also responsible for tracking referrals and requests for information from women with NTD affected pregnancy. Other information lines that offer services for MCH populations include the WIC Hotline, Tobacco Quit Line, and the Lead Program Epidemiology Information Line.

/2010/ DCH's georgiahealthinfo.gov (The Facts of Georgia Health Care) website is a statewide health information web site that provides state residents with free access to cost and quality data for Georgia health care services that helps them navigate through the myriad of health care options available. New web site features were recently unveiled, including long-term care quality comparisons, expanded provider look-up, and clinic and specialty hospitals search tools. Users can view and compare health plans for Medicaid, PeachCare, and insurance providers including Aetna, Blue Cross Blue Shield of Georgia, Cigna, Coventry, Humana, Kaiser, and United Healthcare. In addition to searching more than 130 hospitals, pharmacies, clinics, long-term care facilities, and outpatient centers, users can search a provider's licensing and board certification on the expanded provider look-up, which includes 20,000 physicians.//2010//

Outside of funded MCH activities, there are a number of other program activities comprising the MCH system that significantly impact the Title V population. These programs include Health Check (EPSDT), Right from the Start Medicaid, WIC along with WIC nutrition services, Family Planning, and Immunization, as well as activities focused on CSHCN, such as the Governor's Council on Developmental Disabilities and Social Security determination. The relationship between the MCH program and these activities is described in III. State Overview, Sections C (Organizational Structure) and D (Other Capacity) of this block grant application. The family leadership and support activities are also discussed in the Other Capacity Section.

G. Technical Assistance

The FHB is focusing on systems building related to all levels of the pyramid. The Branch's four requested technical assistance areas reflect this direction. FHB technical assistance needs include: 1) enhancing Women's Health services; 2) integrating FHB services with other MCH providers; 3) providing MCH services in a managed care environment; and 4) maximizing Title V and Title XIX collaboration. /2007/ The FHB is continuing to focus on systems building related to all levels of the pyramid. The Branch's three requested technical assistance areas reflect this direction. FHB technical assistance needs include: 1) enhancing health services for women and men ages 18-21; 2) enhancing emergency preparedness for families and CSHCN; and 3) providing MCH services in a managed care environment.//2007//

/2008/ FHB's FFY 2008 technical assistance needs include: 1) maximization of EPSDT to support vulnerable families; 2) linking public health services to childcare providers; 3) training in socio-emotional development for providers and parents of children birth to age three; and 4) 21st century leadership skills for MCH practitioners. //2008//

/2009/ OBO's FFY 2009 technical assistance needs include: 1) Medicaid reimbursement for fluoride varnishes and 2) data collection around developmental screening.//2009//

/2010/ FFY 2010 technical assistance needs include: 1) development agreements with Medicaid and Title V; 2) data collection methodology for developmental screening; and 3) maximizing Title V and WIC services.//2010//

V. Budget Narrative

A. Expenditures

A. EXPENDITURES

State and federal funds are allocated based on priority needs identified through the MCHBG development process. This process includes reviewing health status and outcomes for women and children, projecting future needs and assessing current capacity/infrastructure. The Branch, in concert with the Division of Public Health, makes recommendations for funding levels for services to women and children. These funding requests are then processed through the Georgia General Assembly's Annual Appropriations Bill. The Department of Human Resources (DHR) also develops a fact sheet on the MCHBG. This fact sheet, which includes Title V requirements, line item description of the Title V budget, and a brief description of each program/service that is funded with Title V funds, is distributed statewide and is used for the public hearing process. Interested partners, stakeholders, families, and advocates are encouraged to provide testimony to the DHR Board on the appropriateness and use of Title V funds.

The state required match on our FFY 2008 MCHBG Budget of \$16,204,321 is \$12,153,241. Using Georgia's Office of Financial Services MCH Block Grant Expenditure Report, the FFY 2008 state match is \$23,217,828 (as of 6/16/09). Georgia's maintenance of effort (MOE) level is \$36,079,622. Our current MOE level is \$43,202,027 for the FFY 2008 grant as of 6/16/09.

B. Budget

BUDGET NARRATIVE

B. NEXT YEAR'S BUDGET

The Department of Human Resources has a system of accountability to monitor the allocation and expenditures of funds provided to local health districts. The department utilizes the computer program, Uniform Accounting System (UAS), where the local health districts' administrative personnel input budget (funds that are allocated by programs such as Children with Special Health Care Needs) and expenditures. The Office of Planning and Budget Services approves all allocations to the local health districts. Reconciliations are made on a quarterly basis. In addition to the department staff, there are staff the Family Health Branch and Division of Public Health levels that monitor programs quarterly and provide technical assistance where needed.

The FFY 2010 Budget for the Federal-State block grant partnership totals \$356,393,668. Of this amount, \$16,465,518 is Title V funds. The remaining amounts represent State Funds totaling \$134,371,463 and \$187,239,849 in Other Funds, and \$18,316,838 in Program Income. Other Federal funds that support Maternal and Child Health (MCH) activities in Georgia are estimated at \$279,042,341. This represents a variety of Federal Programs including three (3) Healthy Start Projects; Emergency Medical Services for Children (EMSC); Women, Infants, and Children (WIC), State Systems Development Initiative (SSDI), Universal Hearing Screening, and Healthy Child Care 2000. This brings the grand total for the State MCH Budget to \$635,436,009 (see line 11 of Form 2).

For FFY 2010, \$137,697,259 is budgeted for Direct Medical Care Services, \$26,492,146 for Enabling Services, \$165,887,769 for Population-Based Services, and \$28,407,724 for Infrastructure Building Services.

The total Federal-State Block Grant Partnership for FFY 2010 includes approximately \$18,316,838 in Program Income (See Form 2, line 6). This income is derived from Medicaid

earnings for services provided to pregnant and post partum women, preventive health care services to children, and reproductive health services to women.

Of the Title V requested allocation (\$16,465,518), \$7,493,444 or 45.51% is earmarked for preventive and primary care for children. Infants < 1 year old - The block grant funds (\$3,209,059) are used to support the Vaccines for Children's Program, positions and administration of High Risk Infant Follow-up - home visits for medically fragile infants and newborns. Title V-leveraged services for this population include: Pregnancy Related Services - Medicaid post partum home and clinic visits through 1st year of life, Neonatal Intensive Care Unit (NICU) Benefits and Administration - 6 tertiary centers statewide which provide clinical care and education services for high risk newborns, education to prevent Sudden Infant Death Syndrome (SIDS), single point of entry - Children 1st, MCH Drugs, and staffing for Local Health Districts; Children 1-22 years old: Title V funds (\$5,282,856) are used in this area for, Lead Based Poisoning, Oral Health (contract with Richmond County Board of Health to provide dental services to mothers, infants, and children in the Augusta health district and to provide training opportunities for pediatric dental residents in a mobile clinic environment.), and Vaccines for Children. The Title V-leveraged services for this population include EPSDT Health Check - quality assurance, Children 1st, School Health - Georgia Cooperative Health Manpower Education Program (CHEP) contract for public health and school nurse training, school health programs in 5 health districts and other technical assistance for school nurses, staffing for Local Health Districts, Family Connection - help partners strengthen families in Georgia by building their capacity to develop relationships and implement community-driven plans, linking community priorities and efforts to state decision makers and promote "what works" using research and evaluation, and connecting partners to each other and to the statewide network of 159 Family Connection county collaborative, and the MATCH Program - a system that supports services for children with severe behavior and/or health problems. Approximately 48.62% (48.62), or (\$7,347,088), is earmarked for Children with Special Health Care Needs to support Genetic/Sickle, Children Medical Services and Pediatric AIDS. There is 7.54% or \$1,241,731, earmarked for Title V administrative costs, used to support positions and administration. These positions provide data, quality assurance, technical assistance, policy, planning, and operational services that support and enhance the State's MCH system. These percentages are in keeping with the 30/30 required by Title V. The remaining \$383,255 is used to support comprehensive health services for (pregnant) women. The Title V leveraged services are: Babies Born Healthy - prenatal care for uninsured low income, six Tertiary Care Centers - high risk maternal services, and MCH Drugs.

We do not anticipate any budget issues relative to MCH Block Grant Match requirements for the FFY 2010 budget.

An attachment is included in this section.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.